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# **Eating Disorders in Men and South Asian Women**

**by**

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A thesis submitted in partial fulfilment of the requirements for the degree  
of Doctor in Clinical Psychology (D. Clin. Psych)

Coventry University, Faculty of Health and Life Sciences and

The University of Warwick, Department of Psychology

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## **Declaration**

This research was carried out under the supervision of Dr. Helen Liebling-Kalifani and Dr. Ken Goss. The ideas of the research and design were collaborated with the named supervisors.

I have conducted, transcribed and analysed all of the interviews. The interviews were peer reviewed to check the validity of my analysis. My supervisors have checked drafts of the thesis and apart from the aforementioned collaborations; the thesis is my own work. The literature review is being prepared for submission to European Eating Disorders Review (Dave, Goss & Liebling-Kalifani). The empirical paper is being prepared for submission to the Psychology of Women's Section Review (Dave, Liebling-Kalifani & Goss). This thesis has not been submitted for any other degree or any other institution.



## List of Abbreviations and Measures

<b>AN</b>	Anorexia Nervosa
<b>ATFRS</b>	Attitudes Towards Family Roles (Hoffman & Kloska, 1995)
<b>BCS</b>	Body Comparison Scale (Fisher, Dunn & Thompson, 2002)
<b>BDI</b>	Beck Depression Inventory (Beck, Ward & Mendelson, 1961)
<b>BDI-II</b>	Beck Depression Inventory (9P) (Beck, Steer & Brown, 1996)
<b>BES</b>	The Body-Esteem Scale Revised (Mendelson, White & Mendelson, 1998)
<b>BIV</b>	The Biographic Inventory for Diagnosis of Behavioural Disturbances (Jaeger, Lischer, Muenster & Ritz, 1976)
<b>BMI</b>	Body Mass Index (See <i>Centers for Disease Control and Prevention, 2006</i> , for the formula)
<b>BN</b>	Bulimia Nervosa
<b>BPSS</b>	Body Parts Satisfaction Scale (Bohrnstedt, 1977)
<b>BSRI-s</b>	Bem Sex Role Inventory-Short form (Bem, 1974)

## List of Abbreviations and Measures

<b>BULIT-R</b>	Bulimia Test-revised  (Thelen, Farmer, Wonderlich & Smith, 1991)
<b>CDRS</b>	The Contour Drawing Rating Scale  (Thompson & Gray, 1995)
<b>CES-D</b>	The Centre for Epidemiological Studies-Depressed Mood Scale  (Radloff, 1977)
<b>CTQ</b>	Childhood Trauma Questionnaire  (Bernstein & Fink, 1997)
<b>DAS</b>	Dysfunctional Attitude Scale  (Weissman, 1979)
<b>EAT</b>	The Eating Attitudes Test  (Garner, Olmstead, Bohr & Garfinkel, 1982)
<b>EDBQ</b>	Eating Disorder Belief Questionnaire  (Cooper et al, 1997)
<b>EDI</b>	Eating Disorders Inventory  (Garner, Olmsted, &. Polivy, 1983)
<b>EDNOS</b>	Eating Disorder not Otherwise Specified
<b>EEI</b>	Eating Expectancies Inventory  (Hohlstein et al., 1998)

## List of Abbreviations and Measures

<b>EOQ</b>	Exercise Orientation Questionnaire  (Yates, Edman, Crago & Crowell, 2001)
<b>FIS</b>	Femininity Ideology Scale  (Tollman & Porsche, 2000)
<b>FRNS</b>	Female Role Norms Scale  (Lefkowitz, Shearer, Gillen & Espinosa-Hernandez, 2006)
<b>HAM-D-17</b>	Hamilton Rating Scale for Depression  (Hamilton, 1960)
<b>HARS</b>	Hamilton Anxiety Rating Scale  (Hamilton, 1959)
<b>MBSRQ</b>	Multidimensional Body-Self Relations Questionnaire  (Cash, 2000)
<b>MEBBIE</b>	The Male Eating Behaviour and Body Image Evaluation  (Kaminski, Chapman & Temple, 2004)
<b>MRNS</b>	Male Role Norms Scale  (Thompson & Pleck, 1986)
<b>MSPSS</b>	The Multidimensional Scale of Perceived Social Support  (Zimet, Dahlem, Zimet & Farley, 1988)
<b>SATAQ-3</b>	Sociocultural Attitudes Towards Appearance Questionnaire  (Heinberg & Thompson, 1995)
<b>SBIQ</b>	Supplemental Body Image Questionnaire  (Mintz and Betz, 1988)



## List of Abbreviations and Measures

**SCID-P**        The Structured Clinical Interview for DSM-III-R – Patient Edition  
(Spitzer et al., 1990)

**STAI**         State-Trait Anxiety Inventory  
(Spielberger, 1970)

**TFEQ**        The Three-Factor Eating Questionnaire  
(Neumark-Sztainer, Sherwood, French & Jeffery, 1999)

**WMH-CIDI**   The World Mental Health – Composite International Diagnostic  
Interview.  
(Kessler & Ustun, 2004)

**WMQ**        Weight Management, Eating, and Exercise Habits Questionnaire  
(Ousley, 1986)

**Anger Discomfort Scale**, Sharkin & Gelso, (1991)

**Collective membership self-esteem**, Luhtanen & Crocker, (1992)

**Rosenberg Self-Esteem Inventory**, Rosenberg, (1965)

**Self Concept Clarity Scale**, Campbell, Trapnell, Heine, Katz, Lavalee & Lehman  
(1996)

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## Summary

Eating disorders is considered as a well researched area. Although, an increasing number of mental health clinicians are becoming better equipped in recognising eating disorders in individuals, specialist eating disorder services still under-represent various groups. This doctoral thesis examines two of those groups specifically, men and ethnic minorities, in particular for the latter, South Asian women and eating disorders.

The first paper reviews published research and examines the link between eating disorders in men and gender differences. It specifically focuses on the factors, which are argued to have a causal link to the development and maintenance of eating disorders in men. It further examines the validity and reliability of eating disorder research in this area and explores the implications for clinical practice.

The second paper presents an empirical study exploring the development and experiences of eating disorders in South Asian women including a comparative analysis with Caucasian women. The final paper provides a reflective account of my journey in carrying out this research.



## **Chapter 1: Literature Review**

# **An Analysis and Review of Eating Disorders: Men and Gender Differences**

Submission to: European Eating Disorders Review

Word Count: 6454 excluding tables and references

## 1.1 Abstract

The vast majority of existing literature examines the factors influencing eating disorders in women. In comparison few studies have explored eating disorders in men. This literature review aims to fill this gap by examining the contributing factors of eating disorders in men. A gendered analysis of eating disorders focusing on aetiology, effects and treatment of eating disorders in men is outlined.

This review also provides an analysis of research studies that identify the key influential factors contributing to eating disorders in men; these include body dissatisfaction, trauma, sexuality, media and societal influences. As research has also identified the likelihood of eating disorders remaining undiagnosed, this notion is also discussed. By exploring the similarities and differences between men and women with eating disorders an introductory understanding of the disorder in men is offered. Finally, the clinical implications are discussed and suggestions for future research are proposed.



## 1.2 Introduction

The Diagnostic and Statistical Manual of Mental Disorder (DSM-IV, American Psychiatric Association, [APA], 1994) identifies three diagnostic sub-types of the diagnosis of eating disorders. These are: i) anorexia nervosa (weight loss due to severely restricting food intake) ii) bulimia nervosa (restricting food intake and binges often followed by purging behaviours) and iii) eating disorders not otherwise specified (including binge eating disorder and any other disorder different from anorexia or bulimia). Eating disorders have been researched for hundreds of years (Reijonen, Pratt, Patel, & Greydanus, 2003). The first report of an eating disorder in a man was published in 1689 by Morton (as cited in Carlat, Camargo, & Herzog, 1997). However, since then research has continued to focus on women despite the increase in the number of men being diagnosed with eating disorders over recent years. Men with eating disorders may be under-researched due to the limited number of clinical samples available. This in turn affects the evidence based practice of mental health clinicians in providing services to men with eating disorders (Siegel, Hardoff, Golden & Shenker, 1995).

The following sections will provide an introductory overview of eating disorders in men, including an outline of epidemiological information. The sections are informed by a review of published literature and sub-sections have been identified accordingly, these include co-morbid psychological problems, age, body image, media influences, sexuality, ethnic differences and abuse histories. Screening measures are important in identifying and diagnosing eating

disorders and therefore the validity of the assessments used by clinicians are also examined.

The overall aim of this literature review is to examine the similarities and differences between men and women with eating disorders and to gain a further understanding of the particular risk factors for men.

### *1.2.1 Literature search strategies*

Three search strategies were used to establish the literature included in this review. Firstly, between September 2007 and February 2008 major databases were used to search for empirical papers. Initially only research published between the years 1998-2008 were reviewed, however due to the lack of research in this area it was considered relevant to use important key literature dating back to 1980. This excluded peer-reviewed publications in non-English languages. Findings from earlier years had informed future research and therefore were not excluded when assessing developments in research for men and eating disorders. The major databases searched included, PsycINFO, Medline (OVID), ScienceDirect. The following major search terms were used: *males, men, gender and eating disorders, anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified*. Further additional terms used included *eating distress, media, trauma and body image*. Secondly, general searches were then carried out to determine references to other publications containing the search terms. Thirdly, all past issues of the International Journal of Eating Disorders and the European Eating Disorders Review were searched for additional relevant publications. These research publications were then collated and the process



repeated until no new references were found. All of the articles reviewed are identified in Table.1 and have been arranged from the emerging themes of the literature found.

Table 1 showing literature reviewed on Eating Disorders in Men and Gender Differences

Authors & publication year	Focus/Title	Number of participants (n)	Mean age of participants (in years)	Sample and Country of study	Eating disorders diagnosis of sample	Measures	Findings
<b>Gender differences</b>							
Woodside and Kaplan 1994	Day hospital treatment in males with eating disorders- response and comparison to females	15 men 334 women	Not reported	Day hospital patients Canada	AN BN	EAT, EDL, FAM, BDI, HAM-D-17 HARS Rosenberg Self-Esteem Inventory	Men are able to be treated in the same setting with majority women. Men have similar treatment response as women.
<b>Co-morbid psychological problems</b>							
Santos, Richards and Bleckley 2007	Comorbidity between depression and disordered eating	101 men 101 women	16.40 69% Caucasian 23% Hispanic 8% ethnicity unknown	High school students America	None clinical Sample	BMI CES-D EAT Rosenberg Self-Esteem Inventory BES MSPSS	Positive relationship between depressive and disordered eating symptoms for both genders

Authors & publication year	Focus/Title	Number of participants (n)	Mean age of participants (in years)	Sample and Country of study	Eating disorders diagnosis of sample	Measures	Findings
Fava, Abraham, Alpert, Nierenber, Pava & Rosenbaum1996	Gender differences in Axis I comorbidity among depressed outpatients	135 men 261 women	39.3 (men) 37.9 (women)	Outpatient America	BN	SCID-P, HAM-D-17	History of alcohol abuse is more common in men whereas BN is more common in women
Bramon-Bosch, Troop and Treasure 2000	Eating disorders in males	30 men 30 women	Not reported	Outpatient United Kingdom	AN BN EDNOS	BMI	Men with eating disorder had stronger psychiatric comorbidity
<b>Age</b>							
Keel, Baxter, Heatherton & Joiner, 2007	A 20-year longitudinal study of body weight, dieting and eating disorder symptoms	Total: 654 465 women 189 men 81% White 5% Black 4% Hispanic 1% mixed/other	Mean age at follow-up 40	College Students America	None clinical sample	BMI, EDI	Men's perception of weight and frequency of dieting increased as they aged



Authors & publication year	Focus/Title	Number of participants (n)	Mean age of participants (in years)	Sample and Country of study	Eating disorders diagnosis of sample	Measures	Findings
<b>Body Image</b>							
Gillen & Lefkowitz 2006	Gender role development and body image among male and female first year college students	Total: 434 52% men 48% women 39% European American 32% African American 29% Latin American	18.5	College students America	None clinical sample	BMI, CDRS, MBSRQ, BSRI-s, ISR, MRNS, FRNS, ATFRS	Gender role attitudes was associated to body image and men had more positive body image compared to women
Kushubeck-West, Mintz & Weigold 2005	Separating the effects of gender and weight-loss desire on body satisfaction and disorders eating behaviour	Total: 191 87 males 22 females 63% European American 7% African American 20% Asian American 6% Hispanic 4% racial/ethnic identity other or unknown	18.5	University students America	None clinical sample	BPSS, WMQ, RSES, SBIQ	The desire to lose weight is important in understanding gender



Authors & publication year	Focus/Title	Number of participants (n)	Mean age of participants (in years)	Sample and Country of study	Eating disorders diagnosis of sample	Measures	Findings
Drewnowski & Yee 1987	Men and body image	98 men 128 women	18.7 men 18.5 women	College students America	None clinical sample	BMI	Women were more likely than men to engage in restrictive calorie diets than men
<b>Media influences</b>							
Cahill and Mussap, 2007	Emotional reactions following exposure to idealized bodies predict unhealthy body change attitudes and behaviour in women and men	93 males 133 females	Males: 22.34 Females: 22.42	University students Australia	None clinical sample	BMI, , SATAQ-3, BCS, Rosenberg Self-Esteem Inventory, BDI-II, Self Concept Clarity Scale, EDI	Gender differences were found in the emotional reactions following exposure to idealized bodies and its consequences.

Authors & publication year	Focus/Title	Number of participants (n)	Mean age of participants (in years)	Sample and Country of study	Eating disorders diagnosis of sample	Measures	Findings
<b>Sexuality</b>							
Kaminski, Chapman, Haynes & Own 2005	Body image, eating behaviours, and attitudes toward exercise among gay and straight men	Total: 50 86% European Americans 8% Latinos 2% Asian Americans 2% African Americans	30.86	Community America	None clinical sample	MEBBIE	Gay men were more likely to than heterosexual men to have distorted cognitions regarding an ideal physique.
Feldman & Meyer 2007	Eating disorders in diverse lesbian, gay and bisexual populations.	Total: 524 LGB Respondents: 396 50% Male 50% Female 34% White 33% Black 33% Latino Heterosexual Respondents: 128 White 51% Men 49% Female	32	Community America	None clinical sample	WMH-CIDI, Collective membership self-esteem scale	Higher significant prevalence of eating disorders in gay and bisexual men compared with heterosexual men

Authors & publication year	Focus/Title	Number of participants (n)	Mean age of participants (in years)	Sample and Country of study	Eating disorders diagnosis of sample	Measures	Findings
<b>Ethnic differences</b>							
Aruguete, DeBord, Yates and Edman (2005)	Ethnic and gender differences in eating attitudes among black and white college students	424 37% male 63% female 225 Black, 199 White,	22	University students America	None clinical sample	BMI, EDI, EOQ, Anger Discomfort Scale	Caucasian participants were more dissatisfied with their bodies than their Black counterparts
<b>Childhood Abuse</b>							
Mitchell and Mazzeo 2005	Mediators of the association between abuse and disordered eating in undergraduate men	168 Men 54.2% Caucasian 26.2% African American 10.7% Asian American 3.6% Hispanic 5.4% Ethnicity unknown	19.7	University students America	None clinical sample	CTQ TAS-20 CES-D STAI PSS BULIT-R	Physical abuse and neglect were associated with disordered eating



Authors & publication year	Focus/Title	Number of participants (n)	Mean age of participants (in years)	Sample and Country of study	Eating disorders diagnosis of sample	Measures	Findings
Kinzl, Mangweth, Traweger & Biebl 1997	Eating-disordered behaviour in males: The impact of adverse childhood experiences	450 Caucasian men	22.4	University students Austria	None clinical sample	EDI BIV	Negative family experiences may increase the risk for eating disorders
<b>Assessments</b>							
Boerner, Spillane, Anderson & Smith 2004	Similarities and differences between women and men on eating disorder risk factors and symptom measures	214 Men 215 Women 90% Caucasian	18.83 Men 18.48 Women	University students America	None clinical sample	BULIT-R EEI TFEQ EAT Restraint scale	Risk and symptom measures developed and validated on women can be used with men

### *1.2.2 Epidemiology of eating disorders in males*

The research reviewed indicates that statistics on the number of men with eating disorders vary. According to the United Kingdom Eating Disorders Organisation 'Beat' (2000) the most common estimate of males with eating disorders is 10% and the National Statistics Online (2004) report that the rate of specific eating disorders anorexia nervosa and bulimia nervosa are very small and almost insignificant in males compared with women. However, researchers have estimated of the number of boys and men with anorexia nervosa and bulimia nervosa is within the range of 5-15% (Andersen, 1995; Lucas, Beard, Kruland & O'Fallon, 1991; Carlat & Camargo, 1991) with 40% of cases of binge-eating disorder in this gender group (DSM IV, 1994). The Parliamentary Office of Science and Technology (2007) reported that under-diagnosis is why an accurate estimate of the number of men with eating disorders is difficult. Braun, Sunday, Huang and Halmi (1999) identified an increase in men accessing treatment for eating disorders. It is unclear if this is due to more men experiencing eating disorders or an increase in the understanding and awareness of the disorder in men. It may also be that the understanding of men with eating disorders is increasing in mental health practitioners therefore contributing to the apparent increase in access (Lewinsohn, Seeley, Moerk and Striegel-Moore, 2002).

### *1.2.3 Prevalence of eating disorders*

Studies have estimated figures for the lifetime prevalence of any eating disorder for example; Kjelsås, Bjørnstrøm and Götestam (2004) suggested the prevalence was 17.9% amongst women and 6.5% among men. This proportion



is supported by Hudson, Hiripi, Pope and Kessler (2007) who found that the lifetime prevalence of eating disorders was up to three times as high for women compared to men.

### 1.3 Gender differences

The diagnosis of men with eating disorders is carried out using the same means and criteria as for women (Anderson, 1999). Research indicates that similarities in psychological characteristics have been found between men and women with eating disorders (Geist, Heinmaa, Katzman & Stephens, 1999; Anderson & Holman, 1997). However, research has also revealed significant differences between the genders such as the higher prevalence of homosexuality and pre-morbid maximum weights (for example, Carlat, Camargo, & Herzog, 1997; Williamson, 1999; Edwin & Andersen, 1990), and stronger psychiatric co-morbidity (Bramon-Bosch, Troop & Treasure, 2000) in men.

Women are more likely to seek treatment for eating disorders than men (Lewinsohn, Seeley, Moerk & Striegel-Moore, 2002). Whilst this may suggest that fewer men suffer with eating disorders than women it may be that fewer men feel able to access services. Some research has argued that men do experience eating disorders but are discouraged from accessing appropriate services due to societal, media and cultural influences. Weltzin et al (2005) suggested that possible difficulties in accessing treatment for men with eating disorders includes cultural biases as the disorder is perceived as a predominately female one. Woodside and Kaplan (1994) compared day hospital eating disorders treatment response by comparing men and women engaging in intensive group therapy.



They found that men were able to receive appropriate treatment within an environment which was dominated by women patients and both genders responded similarly in treatment intervention provided. They noted that there was a large difference between the men and women patients available for the study i.e., 15 men and 334 women. This difference in participant numbers may not have uncovered additional risk factors for men with eating disorders and thus could have biased the overall results.

Weltzin et al. (2005) suggested that men are less likely than women to engage in typical eating disorder behaviour such as self-induced vomiting and are more likely to exercise to lose weight. The authors suggested that men are more likely to engage in binge eating rather than restricting foods.

The research reviewed indicates that the risks of eating disorders in men are multi-factorial as they are in women (see table 1), some of the key risks for men are therefore examined in this paper and their similarities and differences with women are discussed.

### *1.3.1 Co-morbid psychological problems*

Several researchers have identified a co-morbid relationship between depressive disorders and eating disorders (for example, Perez, Joiner, & Lewinsohn, 2004; Leon, Fulkerson, Perry, Keel & Klump, 1999). Santos, Richards and Bleckley (2007) carried out a study with 101 men and 101 women students and examined the co-morbidity between depression and disordered eating. The authors suggested that depression and eating disorders in high school students are of a

similar nature in both men and women and a positive relationship was observed between depressive and disordered eating symptoms. The authors recognised that the findings may have been limited to certain groups as the results were based on self-report measures and those who were experiencing significant symptoms may have been less likely to respond.

Fava et al (1996) examined the gender differences in co-morbid psychological difficulties among depressed outpatients. They identified that women were more likely to meet the criteria for bulimia nervosa along with a co-morbid presentation of Major Depressive Disorder (MDD) as compared to men. Their findings also suggest that men were more likely to have a lifetime history of alcohol and substance abuse than women with MDD. Their research supports the notion that a difference between the two genders exists in relation to mental health difficulties. However, the reasons for these findings need to be explored to assess whether it is that one disorder may be more socially acceptable than the other for example, alcohol abuse may be more socially acceptable in men than eating disorders. This study was carried out with a sample of outpatients with unipolar non-psychotic major depression therefore it can be assumed that due to the specific sample used the findings may not be generalised to inpatients with major depressive disorder or to people without Major Depressive Disorder. One of the conditions for this study was that participants were not misusing alcohol or drugs during the time of the study therefore the study cannot be generalised to this group either. Striegel-Moore, Garvin, Dohm and Rosenheck (1999) found a high prevalence of substance abuse difficulties in men with eating disorders



therefore excluding substance misuse in this gender group such as in Fava et al's study may restrict the finding's representation.

Bramon-Bosch et al. (2000) carried out a study of 30 men and 30 women patients with eating disorders from a specialised eating disorders unit. They found that co-morbidity; primarily anxiety and depressive disorders were present in 66.7 per cent of men and 13 per cent of women from which they concluded a strong psychiatric co-morbidity in men with eating disorders. In addition to this they suggested that eating disorders in men may be more noticeable when an additional morbidity is present. They also identified that poor body image and insufficient social support were particular risk factors for disordered eating in men. The research however did not examine whether it is the depressive symptoms which may have triggered the eating disorder or if the depression is a consequence of the eating disorder.

The research suggests that co-morbidity exists between depression and eating disorders. The clinical implication of this is that people with co-morbidity of the two disorders may find that one of the disorders may go undetected by professionals. Due to the rarity of eating disorders in men clinicians may focus on the depressive and anxiety disorders.

### *1.3.2 Age*

It has been suggested that the onset of eating disorders occurs at an earlier age in men than in women. In a literature review carried out by Sterling and Segal

(1985) the mean onset of eating disorders in men was 14 years of age compared to 17 years for women. This is contradicted by other researchers who have suggested that men have a delayed onset of eating disorders compared to women (Sharp, Clark, Dunan, Blackwood & Shapiro, 1994; Carlat & Camargo, 1991) and a delay of an average of five years has been suggested by Bramon-Bosch et al. (2000). One could suggest that over time the mean age of onset for eating disorders in men has increased. For anorexia nervosa in women, research has suggested that puberty is a high-risk stage for developing an eating disorder (e.g., Braun, Sunday, Huang, & Halmi, 1999) therefore it follows that as puberty begins on average later in boys than girls (Offer, Schonert-Reichl & Boxer, 1996) the onset of eating disorders too is delayed in men. Zehr, Culbert, Sisk and Klump (2007) had also suggested that pubertal timing was associated with disordered eating. They found that adolescent boys who mature earlier than their peers have a higher risk of eating disorder behaviour than boys who mature on time or later.

The research reviewed indicates that family history of eating disorder as a causal factor is well established as a causal factor of adolescent girls. This relationship is also suggested for adolescent boys, particularly for anorexia nervosa and bulimia nervosa (APA, 2000; Manley, Rickson & Standeven, 2000).

Keel, Baxter, Heatherton and Thomas (2007) carried out a 20-year longitudinal study of body weight, dieting and eating disorder symptoms in men and women. They found that age was an important variable in relation to gender differences and eating disorders. From their research they inferred that as men



aged and gained weight an increase in their weight dissatisfaction was apparent. They further suggested that educational and occupational status were not significant in predicting changes in disordered eating in either gender. Women on the other hand were observed to be more accepting of their body shape and weight as they aged. If men become more dissatisfied with their weight as they grow older then the pre-existing socialisation of gender difficulties and the stigma attached to eating disorders as a 'female disorder' may impact upon men accessing eating disorder services. A criticism of this research is that the sample of participants selected was from a private college and therefore narrowed the diversity of education and occupational status.

According to the Parliamentary Office of Science and Technology (2007) the treatment of eating disorders in children and adolescents is under-researched. There is however research that examines the risk factors and associative factors influencing eating disorders in children and adolescents.

### *1.3.3 Body Image*

Body image relates to a person's perception and attitudes to their own personal appearance (McCabe & Ricciardelli, 2004). Studies have indicated that body dissatisfaction can lead to psychological distress regardless of gender. Polivy and Herman (2002) and Stice (2002) argue that poor body image is an important factor in the development and perpetuation of eating disorders; therefore it is appropriate to examine studies regarding men and body image to assess the factors influencing poor body image for this gender group. However, research

using male participants in this area is limited and has tended to include mostly American female participants.

Gillen and Lefkowitz (2006) examined gender role development and body image across a sample that ranged in ethnicity including people from African American, Latin American and European American backgrounds. They carried out a study using a sample of 434 first year American college students, 52% were women and 48% were men. They concluded that men had a more positive body image compared to women and that women were more focused on their appearance. The study found that women who were dissatisfied by their body image desired a smaller figure whereas men who were dissatisfied by their body image ranged from a desire to be smaller to larger. A possible explanation is the socio-cultural pressures on women's appearance which may contribute to this. Gillen and Lefkowitz suggested that men who lack masculine qualities may have poor body image due to difficulties in meeting the cultural norms and expectations of masculinity which may be influenced or directed by media and social expectations. They also studied gender-role attitudes in relation to body image and found that individuals with more traditional gender role attitudes had reported less positive body image than those who held less traditional attitudes. Gillen and Lefkowitz further argued that people with more traditional attitudes were more likely to absorb social and cultural norms with ideals which are difficult to meet. The researchers found no significant difference between African American men and African American women in body image. They identified that European American and Latin American women were more oriented towards their appearance than men that took part in the study. The latter



part of the researcher's findings stresses the importance of cultural differences in gender and eating disorders. The authors acknowledged that their participants were in the process of a transitional period to college, as a consequence appearance related competition may be present among peers which may influence the results of the self report measures.

Kushubeck-West, Mintz and Weigold (2005) argued that females who want to lose weight are more dissatisfied with specific parts of their body such as hips, buttocks and abdomens than their male counterparts. These results are consistent with Anderson (1984) who suggested that men are more concerned with achieving a desirable idealised shape including large shoulders, narrow hips and waist than losing specific weight. In line with Anderson's suggestion a male variant of bulimia nervosa is the newly recognised but under researched disorder 'Machismo Nervosa'. This disorder is a preoccupation of weight and body shape, which is presented by behavioural symptoms of bingeing, calorie control, and abnormal eating habits and weight training (Connan, 1998). Katzman (1997) suggested that the traditional belief that eating disorders are 'female disorders' which is predominately focussed on a preoccupation of body fat needs to be altered to include more diverse body image experiences. This is supported by Drewnowski & Yee (1987) who found that it may not be body dissatisfaction that influences the onset of eating disorders but the actual behaviour which is carried out such as dieting. Drewnowski & Yee carried out a study to examine the desire for thinness or weight gain in men and women. They found that female participants dieted more than male participants and therefore may be at an increased risk for developing eating disorder behaviours. Body dissatisfaction is

not a characteristic exclusive to women. It can be proposed that there may be a connection between body image, body dissatisfaction and eating disorders however the direction of the dissatisfaction is important to acknowledge as some men appear to strive for muscularity whilst others strive for 'thinness' (Silberstein, Streigel-Moore, Timko & Rodin, 1988, Furnham & Calnan, 1998). Other researchers argue that the link between body dissatisfaction and eating disorders is not clear in men (Furnham, Badmin & Sneade, 2002) and therefore requires further research.

An emphasis on achieving and maintaining a 'thin' ideal body weight and shape is suggested to have influenced the high prevalence of eating disorders in groups such as models and ballet dancers (Garner & Garfinkel, 1980). Body image is also important in certain professions. Mickalide (1990) suggested that male jockeys and swimmers are more at risk of developing eating disorders due to the weight restrictions that are enforced by their professions. Nelson and Hughes (1999) reported that male athletes have an increased susceptibility of developing an eating disorder. Body builders and wrestlers were also suggested as groups who were more likely to have a desire to lose more weight than other men (Pope, Katz & Hudson, 1993).

It is important to note that the research is insufficient in this area to suggest a causal link between particular athletic sports and the development of eating disorders, however there may be a sub-population engaging in these sports that are vulnerable and are at risk of developing an eating disorder which could be usefully explored further.



#### *1.3.4 Media influences*

Several studies have shown that the media portrayal of the 'idealised' male and female body image can impact negatively on body satisfaction and mood (e.g., Agliata & Tantleff-Dunn, 2004, Groesz, Levine and Murnen, 2002). Cahil & Mussap (2007) studied the changes in men and women's emotional state following exposure to 'idealised bodies'. They carried out a study using a sample of 133 women and 93 men and assessed the emotional reactions of the genders and found that both men and women participants reacted to exposure of idealised body images. In women the exposure impacted upon mood resulting in increased anger, anxiety and depression. This relates to the co-morbidity of depression and eating disorders as discussed earlier in this review. However in men, the exposure increased the desire to gain muscle and have an athletic build. A weakness of the study acknowledged by the researchers is that the findings accounted for isolated momentary exposure to idealised body images and not for having the repeated exposure that people encounter on a daily basis.

According to Harvey & Robinson (2003) the media tends to emphasise images of men with muscle to advertise products suggesting that body image is favourable. This in turn may influence disordered eating thoughts and behaviours in men. Harvey and Robinson also suggested that men may try to achieve such muscular ideals by strict exercise and dieting and striving for more body mass. It may be possible that an increase of body mass may impact on the under-detection of eating disorders in men as observers may only suspect eating disorder difficulties for weight-loss.

Murray (1991) found that men were less likely to report that they were influenced by media pressure into changing body images, therefore due to the possibility of such reasons; men's self reports of the media influencing eating behaviours should be carefully examined and treated with caution.

Media exposure of high profile people disclosing that they have or have had eating disorders may influence the awareness of eating disorders in both men and women, for example, Princess Diana, Audrey Hepburn, Victoria Beckham and Oprah Winfrey. More celebrity men are also disclosing the same such as Sir Elton John, Billy Bob Thornton and more recently John Prescott ("Prescott", 2008). Research in this area could be usefully expanded upon.

#### *1.3.5 Sexuality*

Research has indicated that homosexual men have higher rates of diagnosed eating disorders and body image concerns (Russel & Keel, 2002) and body dissatisfaction (Harvey & Robinson, 2003) than heterosexual men. Kaminski, Chapman, Haynes and Own (2005) suggested that homosexual men are more likely to experience eating disordered behaviours and symptoms compared to heterosexual men. In their study Kaminski, Chapman, Haynes and Own argued that body dissatisfaction in homosexual men is related to distorted cognitions about their body shape. The study also suggested that there is a high proportion of men who have a drive for muscularity. This can be a particular problem for homosexual men as they are more likely to be concerned about becoming overweight in comparison to heterosexual men, and as the process of building muscle requires body fat, this may prove difficult for them. Feldman and Meyer



(2007) carried out a study in a sample of 126 white heterosexual and 388 White, Black and Latino lesbian, gay and bisexual men and women. They examined the association between an increased focus on appearance within gay communities and the risk of eating disorders. Feldman and Meyer suggested that gay and bisexual men have similar experiences as heterosexual women as both groups revealed a desire to sexually attract men. The study is interesting as it is one of the only studies from this search that used DSM-IV diagnostic criteria for eating disorders in a community based sample of lesbian, gay and bisexual participants as opposed to using a clinical sample. The researchers concluded that there were no significant differences between lesbian and bisexual women compared with heterosexual women however they did find a higher prevalence of eating disorders in gay and bi-sexual men than heterosexual men. They suggested that participation in the gay community was linked to the prevalence of eating disorders. Although the lesbian, gay or bisexual group used participants from White, Black and Latin Americans they only used the responses of White American heterosexuals. This restriction prevented ethnic differences to be accounted for or considered.

Carlat, Camargo and Herzog (1997) had found that although most characteristics of men and women with eating disorders were similar, they identified homosexuality as a specific risk factor for men with eating disorders especially for those with bulimia nervosa. The authors recommended that research exploring the link between sexual preference and eating disorders in men should be carried out.



A link between homosexuality and eating disorders has been suggested and participation in the gay community as a contributing factor for the disorder has been implied. However, few studies were found which examined the different factors of the community as a specific risk factor for eating disorders. Walcott, Pratt and Patel (2003) suggested that research exploring the sexual orientation of boys and men with eating disorders is limited and requires further research.

#### *1.3.6 Ethnic differences*

Aruguete, Nickleberry and Yates (2004) found that White participants were more dissatisfied with their bodies compared with their Black counterparts and thus engaged in more food restrictive behaviours. Their findings also suggested that women were more likely to show body dissatisfaction than men in both Black and White participants and men were less likely to be influenced by societal pressures. This study used self report measures of participants and therefore the reliability of reports by participants may be questioned. Men may respond to questions in a manner that they deem as socially acceptable. In many cultures the concept of experiencing eating disorders is not widely accepted and is often accompanied with the stigma of having a mental health difficulty. Thus people may attempt to conform to the cultural norms to 'fit in' and to avoid shame. According to Welztn et al. (2005) men are less likely to seek treatment than women for eating disorders. Reasons they suggest are cultural and social biases towards eating disorders and women, and also the lack of treatment provisions specifically catering for men with eating disorders. Riccardelli, McCabe, Williams and Thompson (2007) suggested that men from developing countries

whose social structures are changing fast such as South Africa and China, are at greater risk of developing eating disorders compared with more developed countries. One of the reasons suggested is the exposure to the Western influence. They recommended that more research is required into the prevalence of eating disorders in men from minority ethnic backgrounds living in non-Western countries. They suggested that restricted exposure to Western influences may protect non-Western men from risks of developing eating disorders.

### *1.3.7 Childhood Abuse*

Studies have suggested that adverse childhood experiences such as sexual, physical, psychological abuse and childhood neglect could be underlying risk factors for eating disorders. In a review of literature carried out by Connors and Morse (1993) they found that approximately 30% of patients with eating disorders had been sexually abused in childhood. Mitchell and Mazzeo (2005) carried out a study on 168 male volunteers to examine the association between abuse and eating disorder symptoms. Their results suggested that childhood physical abuse and physical neglect were associated with disordered eating. This supports the findings of Kent, Waller and Dagnan (1999) and Striegel-Moore, Dohm, Pike, Wilfley and Fairburn (2002).

Childhood physical and sexual abuse appeared to be more common in men with eating disorders than in men without the disorder (Olivardia, Pope, Mangweth & Hudson, 1995). However, contrary research found no causal link between childhood sexual abuse and eating disorders (Beckman & Burns, 1990; Finn, Hartmann, & Leon, 1986).



Kinzl, Mangweth, Traweger and Biebl (1997) examined the impact of various adverse childhood experiences such as sexual abuse, physical abuse, and dysfunctional family backgrounds and the relationships of these experiences with eating disorders. Of the 301 non-clinical participants they found that rather than a link between sexual or physical abuse in childhood it was the adverse family background causing negative familial relationships that increased the risk of eating disorders in men. They suggested that adverse childhood experiences may initiate inadequate coping mechanisms such as bingeing and chronic overeating. Kinzl, Mangweth, Traweger and Biebl identified that although eating disorders are caused by biological, psychological and socio-cultural factors, they had neglected these influencing variables in the study. They also recognised that if the sample had included clinical populations this may have influenced the overall findings.

It is important to note that that there is no research evidence that proves that sexual abuse is a specific predisposing factor for development of an eating disorder. However, the research strongly indicates that eating disorders in some people may serve as a coping mechanism to deal with abusive childhood experiences. Furthermore, Welch & Fairburn (1994) suggest that adverse childhood experiences such as abuse are not uncommon in people with eating disorders or other psychiatric disorders.

#### 1.4 Conclusion, Discussion and Methodological Limitations

The aims of this review were to highlight the eating disorder literature pertaining to men and outline pertinent gender differences. It is also aimed to identify



salient and specific themes (as highlighted in table 1) as well as risk factors that contribute to the onset of eating disorders in men. These included co-morbidity, age, body dissatisfaction, media, sexuality, ethnicity and traumatic experiences.

The research suggested co-morbidity of eating disorders and depression in men. It is important to highlight that the relationship between the two disorders and further research is required in exploring whether the depression is a trigger for the development of the eating disorder or if it is a consequence of the eating disorder in men. Research identified that similarly to women, pubertal timing is associated with the onset of eating disorders in men, however when exploring if this onset begins earlier for men than women the evidence is contradictory. A review of the literature identified that body dissatisfaction in men ranged from the desire to become thin to the desire to gain muscle. Due to the wide range, eating disorders may not be easily detectable in men. The research exploring media influences suggest that men are influenced by the media exposure of idealised body images and may engage in disordered eating as a result of trying to achieve the 'idealised body'. Research suggests that homosexuality is a specific risk factor for the development of eating disorders in men. However, it is unclear what aspects of sexual orientation trigger the development of eating disorders in men. Literature suggested that as Eastern world countries are becoming increasingly exposed to Western world ideals and therefore are at higher risk of developing eating disorders. Research identified that the onset of eating disorders in men may be influenced by adverse childhood experiences such as abuse however no causal relationship can be presumed.



However, the literature reviewed in this paper is based on recent studies primarily carried out in the United States and little research appears to have been carried out with samples from the United Kingdom and even less from the Eastern world. Cultural differences in males with eating disorders tend therefore to be overlooked, especially for the Eastern world group.

The treatment of male patients with eating disorders appears to follow the same format as for female patients (Fairburn & Harrison, 2003). Fairburn and Harrison suggest that more research on treatment approaches is required. From the literature reviewed it can be concluded that eating disorder studies on men have used small samples from community settings mainly directed at university students. By using undergraduate samples researchers target findings which are more generalised to this group and less generalised to individuals from a clinical population. By excluding the samples the representation of the findings are limited. Researchers have also tended to use a majority of women participants and therefore a lack of an appropriate comparison group of men hinder further advances of research in this area (Santos, Richards & Bleckley, 2007).

As described in the introduction the review examined papers on all the clinical diagnoses of eating disorders and therefore a clear understanding of the risk factors in men with each specific eating disorders sub-type i.e., anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified remains unclear. It may be so that certain life events or characteristics pose an increased risk for the development of a specific eating disorder sub-type that may have been overlooked by merging the disorder sub-types in this review.

### 1.5 Critique of Assessments

Due to the lack of compelling research in this area authors have discussed the impact of the assessment and diagnosis process in identifying eating disorders in men. When examining the subject of eating disorders, researchers often use symptom measures, such as the Bulimia Test-revised (BUILT-R; Thelen, Farmer, Wonderlich, & Smith, 1991), the three-factor eating questionnaire (TFEQ; Stunkard & Messick, 1985) and the Eating Attitudes Test (Garner & Garfinkel, 1979) all of which are validated on women and some authors have found the measurement of eating disorder constructs were less reliable for men (Boerner, Spillane, Anderson & Smith, 2004). Due to the lack of information on the validity of these measures on males (Carlat & Camargo, 1991) the analysis of results using samples of men and psychometric properties in this area may need to be treated with caution. Research using clinical samples is limited as few men in proportion to women access eating disorder services (Soundy, Lucas, Suman & Melton, 1995). In addition to this, diagnostic categories for eating disorders may not reflect the overall characteristics for men (Fairburn & Brownell, 2002). For example, according to the DSM-IV the diagnostic criterion for anorexia nervosa includes amenorrhoea for at least three consecutive menstrual cycles, which is not applicable in men with anorexia. It is therefore important to assess anorexia nervosa in men by lower testosterone levels in a gradual manner (Brownell & Fairburn, 1995). The diagnosis of bulimia nervosa is independent of gender.

Boerner et al. (2004) carried out a study to assess symptom measures in men and women. The sample consisted of 214 men and 215 women and each



participant was administered a range of widely used screening questionnaires to assess symptoms of eating disorders. Their findings suggest that the risk factors of eating disorders for men were similar to that of women, they also identified that although some of the measures were less reliable in men than women the differences were negligible in most cases. The authors concluded that the reliabilities were, overall, adequate for both males and females and therefore although the measures were validated on women they can also be used with men. It has however been suggested that the assessments may need to increase their relevance to men (Oates-Johnson & DeCourville, 1999).

### 1.6 Clinical implications and Recommendations

Eating disorders can be a life-threatening illness for example anorexia nervosa has a mortality rate as high as 15% (APA, 2000). The treatment for such disorders is therefore vital regardless of gender. As a result it is important for clinicians to understand the treatment interventions that would be more effective with men. Although many of the studies suggest that eating disorders in men closely resemble eating disorders in women it is important to identify the differences between the genders. The prevalence of eating disorders is suggested to be similar in men and women (Westenhoefer, 2001). It is therefore suggested that diagnosing eating disorders and providing treatment interventions can be offered to men in the same way as they are offered to women (Woodside et al., 2001).

An examination of the key factors suggested is important to help aid early diagnosis of eating disorders and to target treatment interventions for men.

Recovery for patients seems to be most successful for patients to be treated during the early stages of the disorder (see Lock, LeGrange, Agras & Dare, 2001) and the opportunity for disorders to become chronic into adulthood may be reduced or prevented if appropriate intervention is accessed (Santos, Richards & Bleckley, 2007).

Due to the limited of number of studies examining men and eating disorders it was deemed appropriate to amalgamate the different diagnostic sub-types of eating disorder (anorexia nervosa, bulimia nervosa, binge-eating disorder and eating disorders not otherwise specified) when reviewing the studies. A detailed review of the research in each specific diagnosis may prove useful in understanding the prevalence and aetiology of the different diagnostic sub-types of eating disorders in men. This may identify further disparities and likenesses in the presentations and clinical manifestations of eating disorders in men.

A review of the treatment protocols and a further examination of the interventions provided to men with eating disorders would also be useful. Despite NICE recommendations, many areas in the UK are unable to offer specialist treatments locally and approximately only 50% of health authorities have a specialist eating disorder service available within their area (Royal College of Psychiatrists, 2000).

As much of the research is carried out in the United States and Canada it may be that the findings are more applicable to cultures and communities of



individuals in the far West and therefore less applicable to the UK. It is clear from the current literature review that more research to understand eating disorders in men is required using both clinical and community samples. This in turn will help to identify the risks and treatment needs of men in the UK. This will also help to improve GP awareness in identifying eating disorder symptoms in patients, assist assessment processes and guide treatment interventions to be carried out by therapeutic clinicians.

Early detection of eating disorders in boys and men is important and therefore research aiding the understanding of fundamental triggers associated with eating disorders from childhood would be valuable.

It would also be interesting to examine the consequences of men who do not access therapy and the coping strategies that are adopted to continue with triggers to their eating disorder behaviours.

Of the small clinical sample available research examining the personality traits of people who do attend therapeutic services would be beneficial. This will help to identify what encourages some people to access therapy and what traits deter some men from accessing therapy. There has been little documentation of findings from longitudinal studies using participant samples of men with eating disorder. Such studies would prove beneficial in increasing the understanding of the journey of eating disorders in men and thus may help clinicians in guiding treatment access and interventions.



It is clear from this review that there are many factors which may contribute to the ongoing reluctance of men to seek treatment for eating disorders, which is stereotypically known as a female disorder. As a result this may contribute to the disorder going unrecognised or undiagnosed in men. Increased public awareness is required to help reduce the stigma attached to eating disorders as a 'female disorder' as this would help men to overcome some of the obstacles of accessing eating disorder services such as shame and social expectations. Research exploring ways in which the media may be able to increase the social acceptance will help reduce the stigma attached with the disorder.

### 1.7 References

- Agliata, D., & Tantleff-Dunn, S. (2004). The impact of media exposure on males' body image. *Journal of Social and Clinical psychology*, 23, 7-22.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Anderson, E. (1984). Anorexia nervosa and bulimia in adolescent males. *Pediatric Annals*, 13, 901-907.
- Andersen, A. E. (1990). *Males with eating disorders*. New York: Brunnel/Mazel.
- Andersen, A. E. (1995). Eating Disorders in Males. In K. D. Brownell., & C. G. Fairburn (Eds.), *Eating disorders and obesity: a comprehensive handbook* (pp. 177-187). New York: Guilford Press.
- Anderson, E. A., & Holman, J. E. (1997). Males with eating disorders: challenges for treatment and research. *Psychopharmacology Bulletin*; 33; 291-299.
- Aruguete, M. S., Nickleberry, L. D., & Yates. A. (2004). Acculturation, Body Image, and Eating Attitudes among Black and White College Students. *North American Journal of Psychology*, 6, 393-404.
- BEAT. (2000). Retrieved February 24, 2008, from <http://www.b-eat.co.uk/Home>
- Boerner, L. M., Spillane, N. S., Anderson, K. G., & Smith, G. T. (2004). Similarities and differences between women and men on eating disorder, risk factors and symptom measures. *Eating behaviours*, 5(3), 209-222.
- Bramon-Bosch, E., Troop, N. A., & Treasure, J. L. (2000). Eating disorders in males: a comparison with female patients. *European Eating Disorders Review*, 8(4), 321-328.



- Beckman, K. A., & Burns, G. L. (1990). Relation of sexual abuse and bulimia in college women. *International Journal of Eating Disorders*, 9, 487-492.
- Braun, D. L., Sunday, S. R., Huang, A., & Halmi, K. A. (1999). More males seek treatment for eating disorders. *International Journal of Eating Disorders*, 25, 415-424.
- Brownell, K. D., & Fairburn, C. G. (Eds.) (1995) *Eating Disorders and Obesity: A Comprehensive Handbook*. New York: Guilford Press.
- Cahill, & Mussap. (2007). Emotional reactions following exposure to idealised bodies predict unhealthy body change attitudes and behaviours in women and men. *Journal of Psychosomatic Research*, 62(6), 631-639.
- Carlat, D. J., & Camargo, C. A. (1991). Review of bulimia nervosa in males. *American Journal of Psychiatry*, 148, 831-843.
- Carlat, D. J., Camargo, C. A., & Herzog, D. B. (1997). Eating disorders in Males: A report on 135 patients. *American journal of Psychiatry*, 154(8), 1127-1132.
- Connan, F. (1998). Machismo Nervosa: An Ominant Variant of Bulimia Nervosa? *European Eating Disorders Review*, 6, 154-159.
- Connors, M. E., & Morse, W. (1993). Sexual abuse and eating disorders: A review. *International Journal of Eating Disorders*, 13, 1-11.
- Drewnowski, A., & Yee, D. K. (1987). Men and body image: Are males satisfied with their body weight? *Psychosomatic Medicine*, 49, 626-634.
- Edwin, D., & Andersen, A. (1990). Psychometric testing in 76 males with eating disorders. In A. E. Andersen (Eds.), *Males with eating disorders* (pp. 116-130). New York: Brunner/Mazel.
- Fairburn, C. G., & Brownell, K. D. (2002). *Eating Disorders and Obesity. A*

*comprehensive handbook*. 2nd Ed. (pp. 252-253). New York: The Guildford Press.

Fava, M., Abraham, M., Alpert, J., Nierenberg, A. A., Pava, J. A., & Rosenbaum, J. F. (1996). Gender differences in axis I comorbidity among depressed outpatients. *Journal of Affective Disorders*, 38, 129-133.

Fairburn, C. G., & Harrison, P. J. (2003). Eating disorders. *The Lancet*, 361, 407-416.

Feldman, M. B., & Meyer, I. H. (2007). Eating disorders in diverse lesbian, gay and bisexual populations. *International Journal of Eating Disorders*, 40, 218-226.

Finn, S. E., Hartmann, M., & Leon, G. (1986). Eating disorders and sexual abuse: Lack of confirmation for a clinical hypothesis. *International Journal of Eating Disorders*, 5, 1051-1060.

Furnham, A., Badmin, N., & Sneade, I. (2002). Body image dissatisfaction: gender differences in Eating Attitudes, Self- Esteem, and Reasons for Exercise. *The Journal of Psychology*, 136(6), 581-596.

Furnham, A & Calnan, A. (1998). Eating disturbances, self-esteem, reasons for exercising and body weight dissatisfaction in adolescent males. *European Eating Disorders Review*, 6, 58-72.

Garner, D. M., & Garfinkel, P. E. (1979). The eating attitudes test: And Index of the symptoms of Anorexia Nervosa. *Psychological Medicine*, 9, 273-279.

Garner, D. M., & Garfinkel, P. E. (1980). Socio-cultural factors in the development of anorexia nervosa. *Psychological Medicine*, 10, 647-656.

Geist, R., Heinmaa, M., Katzman, D., & Stephens, D. (1999). A comparison of



male and female adolescent referred to an eating disorder program.

*Canadian Journal of Psychiatry*. 44. 374-378.

Gillen, M. G., & Lefkowitz, E. S. (2006). Gender role development and body image among male and female first year college students. *Sex Roles*, 55, 25-37.

Groesz, L. M., Levine, M. P., & Murnen, S. K. (2002). The effect of experimental presentation of thin media images on body satisfaction: a meta analytic review. *International Journal of Eating Disorders*. 21,1-16.

Harvey, J. A., & Robinson, J. D. (2003). Eating disorders in men: current considerations. *Journal of Clinical Psychology in Medical Settings*, 10(4), 297-306.

Hudson, J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the national comorbidity survey replication. *Biological Psychiatry*, 61, 348-358.

Kaminski, P. L., Chapman, B. P., Haynes, S. D., & Own, L. (2005). Body image, eating behaviours, and attitudes towards exercise among gay and straight men. *Eating Behaviours*, 6, 179-187.

Kashubeck-West, S., Mintz, L. B., Weigold, I. (2005). Separating the effects of gender and weight-loss desire on body satisfaction and disordered eating behaviour. *Sex Roles*, 53, 505-518.

Katzman, M. A. (1997). Getting the difference right: it's the power not gender the matters. *European Eating Disorders Review*, 5, 71-74.

Keel, P. K., Baxter, M. G., Heatherton, T. F., & Thomas, E. Jr. (2007). A 20-Year Longitudinal Study of Body Weight, Dieting, and Eating Disorder Symptoms. *Journal of Abnormal Psychology*, 116, 422-432.

Kent, A., Waller, G., & Dadnan, D. (1999). A greater role of emotional rather than physical or sexual abuse in predicting disordered eating attitudes: The role of mediating variables. *International Journal of Eating Disorders*, 22, 131-138.

Kinzl, J. F., Mangweth, B., Traweger, C.M., & Biebl, W. (1997). Eating-disordered behavior in Males: The impact of adverse childhood experiences. *International Journal of Eating Disorders*, 22, 131-138.

Kjelsås, E., Bjørnstrøm, C., & Götestam, K. G. (2004). Prevalence of eating disorders in female and male adolescents (14-15 years). *Eating Behaviours*, 5, 13-25.

Leon, G. R., Fulkerson, J. A., Perry, C. L., Keel, P.K., & Klump, K. L. (1999). Three to four year prospective evaluation of personality and behavioural risk factors for later disordered eating in adolescent girls and boys. *Journal of Youth and Adolescence*, 28, 181-196.

Lewinsohn, P. M., Seeley, J. R., Moerk, K. C., & Striegel-Moore, R. H. (2002). Gender differences in eating disorder symptoms in young adults. *International Journal of Eating Disorders*, 32, 426-440.

Lock, J., LeGrange, D., Agras, W. S., & Dare, C. (2001). *Treatment manual for anorexia nervosa- a family-based approach*. New York: Guilford Press.

Lucas, A., Beard, M., Kurland, L., & O'Fallon, M. (1991). 50-year trends in the incidence of anorexia nervosa in Rochester, Minn: A population-based study. *American Journal of Psychiatry*, 148, 917-922.

Manley, R., Rickson, S., & Standeven, B. (2000). Children and adolescents with eating disorders: Strategies for school counsellors. *Intervention in School and Clinic*, 35, 228-232.



- McCabe, M. P., & Ricciardelli, L. A. (2004). Weight and shape concerns of boys and men. In J. K. Thompson (Eds.), *Handbook of eating disorders and obesity* (pp. 606-634). New Jersey: Wiley & Sons.
- Mickalide, A. D. (1990). Sociocultural factors influencing weight among males. In A. E. Andersen (Ed.), *Males with eating disorders* (pp. 30-39). New York: Brunner/Mazel.
- Mitchell, K. S., & Mazzeo, S. E. (2005). Mediators of the association between abuse and disordered eating in undergraduate men. *Eating Behaviors*, 6, 318-327.
- Murray, S.H. (1991). Sociocultural factors in eating disorders. Unpublished doctoral thesis, University of Sydney. Australia.
- National Statistics Online. (2004). Retrieved February 24, 2008, from <http://www.statistics.gov.uk>
- Nelson, W., & Hughes, M. (1999). Anorexic eating attitudes and behaviours of males and female college students. *Adolescents*, 34, 621-644.
- Oates-Johnson, T., & DeCourville, N. (1999). Weight preoccupation, personality, and depression in university students: An interactionist perspective. *Journal of Clinical Psychology*, 55, 1157-1166.
- Offer, D., Schonert-Reichl, K. A., & Boxer, A. M. (1996). Normal adolescent development: Empirical research findings. In M. Lewis (Ed.), *Child and adolescent Psychiatry: A comprehensive textbook*. Baltimore: Williams and Wilkins.
- Olivardia, R., Pope, H. G.Jr., Mangweth, B., & Hudson, J. I. (1995). Eating disorders in college men. *American Journal of Psychiatry*, 152(9), 1279-1285

Parliamentary Office of Science and Technology. (2007). Retrieved January 17, 2008, from <http://www.parliament.uk>

Perez, M., Joiner, T., & Lewinsohn, P. (2004). Is major depressive disorder or dysthymia more strongly associated with bulimia nervosa? *International Journal of Eating Disorders*, 36, 55-61.

Polivy, J., & Herman, C. P. (2002). Causes of eating disorders. *Annual Review of Psychology*, 53, 187-213.

Pope Olivardia, R., Pope Jr, H. G., Mangweth, B., & Hudson, J. I. (1995). Eating disorders in college men. *American Journal of Psychiatry*, 152, 1279-1285.

Prescott praised for eating disorder confession. Retrieved April 20, 2008, from <http://www.guardian.co.uk/>

Reijonen, J. H., Pratt, H. D., Patel, D. R., & Greydanus, D. E. (2003). Eating disorders in the adolescent population: An overview. *Journal of Adolescent Research*, 18, 209-222.

Royal College of Psychiatrists. (2000). Eating disorders in the UK: policies for service development and training. Retrieved March 8, 2008, from <http://www.rcpsych.ac.uk/files/pdfversion/cr87.pdf>

Ricciardelli, L. A., McCabe, M. P., Williams, R. J., & Thompson, K. (2007). The role of ethnicity and culture in body image and disordered eating among males. *Clinical Psychology Review*, 27(5), 582-606.

Russel, C. J., & Keel, P. K. (2002). Homosexuality as a specific risk factor for eating disorders in men. *International Journal of Eating Disorders*, 31, 300-306.

Santos, M., Richards, S.C., & Bleckley, K. M. (2007). Comorbidity between



depression and disordered eating in adolescents. *Eating Behaviours*, 8, 440-449.

Sharp, C., Clark, S., Dunan, J., Blackwood, D., & Shapiro, C. (1994). Clinical presentation of anorexia nervosa in males: 24 new cases. *International Journal of Eating Disorders*, 15, 125-134.

Siegel, J. H., Hardoff, D., Golden, N. H., & Shenker, I. R. (1995). Medical complications in male adolescents with anorexia nervosa. *Journal of Adolescent Health*, 16, 448-435.

Silberstein, L. R., Striegel-Moore, R. H., Timko, C., & Rodin, J. (1988). Behavioural and psychological implications of body dissatisfaction: Do men and women differ? *Sex Roles*, 19, 219-232.

Soundy, T. J., Lucas, A. R., Suman, V. J., & Melton, L. J. (1995). Bulimia Nervosa in Rochester, Minnesota from 1980 to 1990. *Psychological Medicine*, 25, 1065-1071.

Stice, E. (2002). Risk and maintenance factors for eating pathology: A meta-analytic review. *Psychological Bulletin*, 128, 825-848.

Stirling, J. W., & Segal, J. D. (1985). Anorexia nervosa in males: A critical review. *International Journal of Eating Disorders*, 4(4), 559-572.

Striegel-Moore, R., Dohm, F., Pike, K., Wilfley, D., & Fairburn, C. (2002). Abuse, bullying and discrimination as risk factors for binge eating disorder. *American Journal of Psychiatry*, 159, 1902-1907.

Striegel-Moore, R. H., Garvin, V., Dohm, F., & Rosenheck, R. A. (1999). Psychiatric comorbidity of eating disorders in men: A national study of hospitalized veterans. *International Journal of Eating Disorders*, 25(4), 399-404.

- Stunkard, A.J. and Messick, S. (1985). The Three Factor Eating Questionnaire to measure dietary restraint, disinhibition, and hunger. *Journal of Psychosomatic Research*, 29, 71–81.
- Thelen, M. H., Farmer, J., Wonderlich, S., & Smith, M. (1991). A Revision of the Bulimia Test: The BULIT-R. *Psychological Assessment* 3(1), 119-124.
- Walcott, D. D., Pratt, H. D., & Patel, D. R. (2003). Adolescents and Eating Disorders: Gender, Racial, Ethnic, Sociocultural, and Socioeconomic Issues. *Journal of Adolescent Research*, 18(3), 223-243.
- Welch, S. L., & Fairburn, C. G. (1994). Sexual abuse and bulimia nervosa: three integrated case control comparisons. *American Journal of Psychiatry*, 151(3), 402-407.
- Welzlin, T. E., Weisensel, N., Franczyk, D., Burnett, K., Klitz, C., & Bean, P. (2005). Eating disorders in men: update. *The Journal of Men's Health & Gender*, 2(2), 186-193.
- Westernhoefer, J. (2001). Prevalence of eating disorders and weight control practices in Germany in 1990 and 1997. *International Journal of Eating Disorders*, 29, 477-481.
- Williamson, I. (1999). Why are gay men a high risk group for eating disturbance. *European Eating Disorders Review*, 7(1), 1-4.
- Woodside, D. B., Garfinkel, P. E., Lin, E., Goering, P., Kaplan, A. S., Goldbloom, D. S., & Kennedy, S. H. (2001). Comparisons of men with full or partial eating disorders, men without eating disorders, and women with eating disorders in the community. *American Journal of Psychiatry*, 158, 570-574.



Woodside, D. B., & Kaplan, A. S. (1994). Day hospital treatment in males with eating disorders- response and comparison to females. *Journal of Psychosomatic Research*, 38(5), 471-475.

Zehr, J. L., Culbert, K. M., Sisk, C. L., & Klump, K. L. (2007). An association of early puberty with disordered eating and anxiety in a population of undergraduate women and men. *Hormones and Behavior*, 52, 427-435.

## **Chapter 2: Empirical Paper**

# **Eating disorders in South Asian women: A comparative analysis of underlying reasons, needs and service implications**

Submission to: Psychology of Women Section Review

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## 2.1 Abstract

The aim of this paper is to explore eating disorders in South Asian women by means of a comparative analysis with Caucasian women. This was carried out by investigating similarities and differences in contributing factors for eating disorders between the two cultural groups. A qualitative methodology was utilised to gain in-depth understandings of the data. Interviews were carried out with a sample of five South Asian participants and five Caucasian participants with eating disorders. Both groups had received therapy from an Eating Disorders Services in the Midlands. A Grounded theory approach was used to analyse the data obtained from the ten interviews. Analyses of interviews suggest there are similarities in the contributing factors influencing the development of eating disorders in South Asian and Caucasian women. However, analysis also revealed differences between the two groups in terms of accessing support for their difficulties. In particular, South Asian participants in comparison to their Caucasian counterparts received very little support due to various cultural factors. Clinical implications based on the research findings are discussed.

## 2.2 Introduction

According to the UK 2001 Census approximately 4.6 million of British residents are from non-white minority ethnic backgrounds and approximately 2.3 million of these have cultural origins in the Indian subcontinent. The Department of Health's document on 'Delivering Race and Equality: A framework for action', cites research suggesting that Black and Ethnic Minority people are likely to experience problems with mental health services (DoH, 2003). These problems include difficulties in accessing services, low satisfaction of services received, reduced chances of having psychological needs addressed within the treatment process and lower access to 'talking' treatments than other service users (DoH, 2003). According to the National Association for Mental Health, 'MIND' (1993) white middle class populations are more likely to have access to talking treatments than their South Asian counterparts. The National Institute for Clinical Excellence and Mental Health (NICE, 2004) reported that most mental health services have struggled to meet the needs of ethnic minority people. It is therefore important for research to help identify gaps within services to aid service providers.

Eating disorders occur when there is a disturbance of usual eating and weight control habits resulting in a clinically significant impairment of psychosocial functioning and/or physical health (Fairburn & Harrison, 2003). Three types of eating disorders are identified by the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, (American Psychiatric Association, [APA] 1994). These are anorexia nervosa, bulimia nervosa and eating disorders



not otherwise specified (see appendix 1 for diagnostic criteria). It is suggested that varying risk factors contribute to the onset of eating disorders, such as personal and family history of perfectionism (Hewitt, Flett, & Ediger, 1995), childhood sexual abuse (Fairburn, Cooper, Doll, & Welch, 1999) and low self-esteem (Button, Sonuga-Barke, Davies, & Thompson, 1996). The National Institute for Health and Clinical Excellence guidelines (NICE, 2004) highlight the importance of early detection and treatment of eating disorders.

### *2.2.1 Gender*

Research has suggested that the number of males reported to experience eating disorders has increased (McComb, 2001) however eating disorders are still more likely to occur in women than men (MIND, 2006). Researchers have argued that women are more likely than men to be concerned with their appearance, in particular their weight (Cooper & Fairburn, 1983; Cash, Winstead, & Janda, 1986; Furnham & Calnan, 1998).

### *2.2.2 Ethnicity & Culture*

There is a high incidence of psychological distress among South Asian women with mental health difficulties such as eating disorders (Bhugra & Bhui, 2003). Eating disorders among Asian females has increased (Rayar & Davies, 1996) and further research has found that eating disorder psychopathology is greater within the female South Asian population compared with the Caucasian population (Anand & Cochrane, 2005). Hall (1995) reported an increase in susceptibility to eating and body image problems for Asian women. The reason

for the observed increase is unclear. It is not known if this is due to more Asian women accessing services; thereby increasing the number of people diagnosed or if this represents an increase in the incidence of eating disorders due to the presence of other factors.

McCourt and Waller (1996) suggest that cultural conflict in South Asian women contributes to eating distress. Similarly, Lake, Staiger and Glowiski (2000) propose that eating disorders may result from the stress of trying to navigate two distinct cultures. This was supported by Hindmarch (2000) who suggested a conflict between traditional values at home and the western values in the community is a contributing factor for eating disorders as people may struggle to adopt an accepted role in both cultures. Lachenmeyer and Muni-Brandner (1988) suggested exposure to Western values for non-Western cultures is linked to vulnerability to eating disorders and increased attention to body weight. Anand and Cochrane (2005) found that South Asian women were vulnerable to feelings of shame regarding their body, which increased the likelihood of eating disordered psychopathology. Family and cultural background may impact on the development of eating disorders to some extent as suggested by Mumford, Whitehouse and Platts (1991). They suggested that Indian girls from traditional Indian backgrounds had an increased risk of developing eating disorders as they are required to adjust to a culture different to that of their family.



Other studies have found no difference between minority ethnic and Caucasian participants in eating disorder psychopathology (Mitchell & Mazzeo, 2004; le Grange, Telch & Agras, 1997; le Grange, Stone & Brownell, 1998; Haudek, Rorty & Barbara, 1999; Williamson, Sedula, Anda, Levy & Byers, 1992).

An increase of Eating disorders in non-Western countries has been suggested (Ritenbaugh, Shisslak & Prince, 1992). The increased promotion of Western ideas may play an important role in the increase of eating disorders in non-Western countries through such means as media influences. As Striegel-Moore, Wilfley, Pike, Dohm and Fairburn (2000) suggested various traditional beliefs held by ethnic minorities were considered as protective factors from illnesses such as eating disorders. The authors suggested that these protective factors appear to be diminishing and individuals appear to be embracing mainstream American culture and therefore contributing to the increase in the frequency of binge eating and purging behaviours in ethnic minorities. This supports the findings from Crago, Shisslak and Estes (1996) who found that women who identify with a Caucasian majority culture are likely to adopt white culture attitudes regarding thinness and excessive dieting. They suggest that the risk factors for developing eating disorders are similar for women regardless of ethnic background.

According to Phinney (1993), contact with one's own ethnic group as well as other ethnic groups is important in the development of one's own

identity. This however may create difficulties for the individual if the ethnic groups in which they are born and the ethnic group they are brought up in have conflicting expectations and rules. Kuba and Harris (2001) suggest that identity confusion is associated with the increased incidence of eating disorders symptoms due to incongruent beliefs and definitions of beauty held by the two ethnicities and cultures.

Acculturation may also influence psychological changes in terms of beliefs and values (Castro, 2003). It would be particularly interesting to study changes in values, norms and attitudes, which may or may not influence body image ideals of ethnic minorities groups from Eastern world countries who emigrate to Western world countries such as the UK and America, and conversely those individuals who move from traditionally Western countries to Eastern countries.

It is important to draw attention to the reliability of the research on ethnicity and eating disorders for three notable reasons identified by Striegel-Moore and Smolak (In Fairburn & Brownell, 2002, p253):

- i) Operational definitions are inconsistent, as exemplified by measures of acculturation (changes within a culture after interaction with another culture);*
- ii) Many instruments have only been validated in majority populations and in women;*
- iii) Current diagnostic categories may not adequately reflect the nature of eating disorders among men and ethnic minority women.*



Much of the research in eating disorders has been carried out with homogeneous Western populations. Therefore the representation of findings in eating disorders psychopathology of non-Western populations is limited and the true magnitude and risk factors of eating disorders in this population is unclear and likely to be an underestimate of the real situation.

### *2.2.3 Eating disorder screening assessments*

Various assessment tools, such as the Eating Attitudes Test (EAT) (Garner & Garfinkel, 1979), BITE (Henderson & Freeman, 1987) and Eating Disorder Inventory, EDI (Garner, 1990), are used to aid diagnosis of eating disorders.

It is suggested that Western diagnostic tools such as the DSM-IV may fail to screen eating disorders in non-Western groups as they may not take into account the specific groups' religious, cultural and beauty practices (King, 1993; Mumford, 1993). Accurate assessment of dietary custom in culturally diverse populations can be hindered by the lack of culturally appropriate and sensitive instruments (Allison, 1995). Research examining the cultural aspects of eating disorders has questioned the "contextual validity" of instruments used in the assessment of eating disorders (Lee & Katzman, 2002). If tools are not culturally sensitive early detection of eating disorders may be impeded. Standard diagnostic classifications may also not be sensitive to various cultural groups and consequently ill equip mental health services in the diagnostic process. Further it is also suggested that culturally sensitive treatments need to be developed (Maj,

Halmi, Lopez-Ibor & Sartorius, 2003), however this can only be done when an understanding of various cultural factors influencing eating disorders is present.

#### *2.2.4 Treatment interventions for eating disorders*

According to NICE (2004) guidelines, Cognitive Behavioural Therapy is the recommended psychological treatment for eating disorders. NICE (2004) also recommend that the treatment process for all eating disorders in children and adolescents should involve the client's family members. However, Gilbert, Gilbert and Sanghera (2004) found that family shame and honour deterred South Asian women from accessing mental health services. This may therefore be another obstacle for South Asian adolescent women as family involvement within treatment process may be unavailable.

#### *2.2.5 Accessing services*

According to MIND (2006) Asians experience difficulties in accessing mental health services due to inappropriate treatment and limited availability of services that cater specifically for needs of Asian people suffering psychological distress.

Many people from minority ethnic populations seek support outside mental health services and seek to address their difficulties through family, friends, community and religious arenas. Stresses for minority ethnic people such as culture, language and family life may be accentuated by external factors such as racism, isolation, discrimination and lack of understanding from peers, colleagues and services- inclusive of mental health services. The National



Survey of NHS patients (1998-2002) reported that people from minority ethnic populations report lower levels of satisfaction with health services.

Many South Asian individuals may experience psychological distress. However due to various cultural factors they do not access the mental health services available. Beliappa (1991) suggested that a lack of awareness of existing mental health support services promote individuals to find alternative methods to cope with distress such as praying, crying or avoidance; however these strategies only provide short-term relief for their difficulties. The impact of not accessing mental health services during early stages is that people may present to services when their needs are acute or have become more chronic. As a result of this, people with acute and chronic difficulties may need to access in-patient services by the time they are referred (Geraghty & Warren, 2003).

Without the knowledge of potential factors influencing psychological distress in ethnic minority groups, service providers are disadvantaged when dealing with service users from ethnic minority backgrounds. Service users may be cautious or hesitant to access services due to the potential stigma attached to mental health, and if they do not feel clinicians understand their cultural background may deter them from seeking help. Service providers might also miss or not recognise subtle inferences made by people, which are potentially important to the service user's psychological distress. Having an awareness of the cultural implications, constraints and demands that service users have upon them is beneficial in providing services and tailoring treatment programmes to

specific individual needs. In 1995 a conference organised by the Muslim Women's Helpline, suggested that positive outcome in treatment is linked to the healthcare providers' sensitivity to culture and spiritual beliefs of service users (Radia, 1996).

Burman, Chantler and Batsleer (2002) argued that when assessing the causes of psychological distress experienced by South Asian women, factors such as gender, culture, race and class need to be considered. The authors went on to recommend the integration of cultural and gender sensitive factors into service provision for South Asian women.

#### *2.2.6 Summary and Current research*

Researchers to date have mainly used qualitative methods to examine factors and influences contributing to eating disorders (Haworth-Hoepfner, 2000; Hesse-Biber, Marino & Watts-Roy 1999). Research has helped mental health service providers to develop their services based on findings from studies predominantly of participants with Caucasian backgrounds.

It is evident from the research discussed above that, if providers are to develop their services to meet the needs of South Asians, there is a need to understand more fully the factors contributing to both the onset of eating disorders and the willingness to access services among South Asian immigrant populations. Hence, the focus of the current research is to establish the factors that impede or help South Asian and Caucasian women with eating disorders to



access appropriate eating disorder services. It also aims to address some existing gaps in the literature by focusing on South Asian and Caucasian women with eating distress with a view to obtaining an in-depth understanding of their opinions regarding their needs and the implications of these for service provision.

### *2.2.7 Research Aims*

The current research study aims to:

1. Conceptualise the underlying reasons why South Asian women develop eating difficulties as compared to Caucasian women;
2. Promote a greater understanding of the maintaining factors of their eating disorder in South Asian and Caucasian women;
3. Explore South Asian and Caucasian women's experiences of a specialist eating disorders service in the Midlands region and their opinions on how it could be improved;
4. Outline the implications of women's views for improving eating disorders services for South Asian and Caucasian women.

## **2.3 Method**

An explorative qualitative method was chosen to address the research aims, as these arise from current gaps in the literature. Qualitative research explores depth and meaning from data, which can only be inferred by statistics, and thus richness of information is available (see Burman, Chantler & Batsleer, 2002).

Grounded theory was chosen for this research as it provided a structured methodology without restricting or influencing the participant's experiences but

instead uses a reflexive approach to elicit key themes and categories important for the participants and relevant to the research aims.

Strauss and Corbin (1990: 24) reported;

*the grounded theory approach is a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon.*

The principles of grounded theory do not apply existing constructs to research but enables constructs to derive solely from the data obtained from the interviews carried out. Hence, in order to obtain in-depth information from the women, semi-structured interviews were carried out with all of the ten participants.

### *2.3.1 Ethical approval*

Ethical approval was granted by Coventry University Ethics Committee (see Appendix 2), National Research Ethics Service (see Appendix 3) and local R & D Committee (see Appendix 4). Informed consent was obtained from the participants prior to the commencement of their participation in the research (see Appendix 7). Ethical conduct and confidentiality was maintained as recommended by the British Psychological Society (2004).

### *2.3.2 Participants*

Participants were recruited from a specialist eating disorder service in the West Midlands area. A total of ten female participants were selected for this study, this included five South Asian participants and five Caucasian participants.



‘South Asian’ was defined as those whose cultural backgrounds originated from India, Pakistan, Bangladesh and Sri Lanka in line with Marshall and Yazdani’s (2000) description. ‘Caucasian’ was defined by the Oxford dictionary (2008) as a “white person; a person of European origin”. Suitability was assessed using the following criteria: The inclusion criteria for both groups were a diagnosis of an eating disorder complying with the criteria identified by the DSM-IV (American Psychiatric Association, 1994), English speaking, aged over 18 years and female. The specialist eating disorder service where the current research was carried out also had an exclusion criteria this included: non-English speaking, under 18 years old, recent history of deliberate self harm, suicidal ideation, planning or intent, illegal drug use, alcohol misuse, diagnosis of psychosis and history of aggressive behaviour.

The ages range for the South Asian and Caucasian samples were 20-52years (mean 36.4) and 19-36years (mean 24.4) respectively. Details of participants are shown in Table 1.

Table 1: Details of participants within each group.

Participant number	Age in years	Describing ethnicity	Eating disorder diagnosis	Body Mass Index (BMI)
South Asian participants				
1	49	British Asian	EDNOS*	20.7
2	34	British Asian	EDNOS	26.3
3	52	Indian by birth Muslim	EDNOS	22.3
4	20	Indian, Punjabi. Sikh Punjabi	EDNOS	23
5	27	Sikh Indian, South Asian, Punjabi	EDNOS	20.7
Caucasian participants				
1	25	White British	BN	23.8
2	19	White British	EDNOS	21.1
3	22	White British	BN	26.7
4	20	White British	BN	17.9
5	36	White British	BN	39

\*EDNOS = Eating Disorders Not Otherwise Specified

\*\*BN = Bulimia Nervosa



### *2.3.3 Data Collection and Analysis*

All of the interviews were carried out in a specialist eating disorder service in the West Midlands. With the consent of the participants, interviews were audio-recorded.

Questions generated for the interviews were guided by the exploration of the research aims and questions arising from gaps in existing literature whilst keeping aspects of the questioning style flexible. Data collection, memoing, coding of categories and saturation are integral components of grounded theory (Strauss & Corbin, 1998). Analytic procedures for the analysis of qualitative data, as described by Strauss and Corbin (1998), were carried out as follows:

- i) Data was collected through means of semi-structured interviews and then transcribed verbatim by the lead researcher;
- ii) Memo writing was carried out during the research with the aid of a research diary. This aids the formulation process of grounded theory. The diary was written immediately after the interview data was collected and included impressions of the interview process such as non-verbal information. This assisted in the articulation of immediate ideas and the development of categories;
- iii) All interview notes were initially coded to help to conceptualise the data.

The line-by-line coding process enabled tentative categorising of emerging themes by identifying and labelling meaning of the interview data. This provided meaning of the data with relevance to the research question taking into account recurring themes;

- iv) Axial coding was then established by identifying categories and the relationship between the categories. Lower order categories were identified and then developed and refined into higher order categories;
- v) Saturation of the codes was achieved when coding and categorising of emerging themes reached a stage whereby no further evidence or contributions to the research could be made. This was achieved at interview five with both groups. The theory developed from the research was emergent directly from the interview data analysed.

#### *2.3.4 Semi-structured interviews*

A semi-structured interview schedule was developed from analysis of key themes and gaps in the existing research literature in this area and through guidance of research supervisors. Charmaz (2000) suggested that formal interviewing is a ‘rich data’ source for grounded theory analysis.

Flick (2002) suggested the need to consider four components in designing an interview. These components were considered in the design and implementation of the interview for the current research as follows:

- i) Non-direction; early hypothesis or evaluations were not made in the interview process which reduced the possibility of participants being guided or influenced by the researcher;
- ii) Specificity; the semi-structured nature of the interview ensured that the participants were less likely to respond with general statements and the focus of the research question was maintained;



iii) Range; the range of questions were kept within the validity of the research purpose;

iv) Depth and Personal Context; depth and personal context shown by the participants were recorded and not dismissed. This is important as examining distress or satisfaction expressed by the participant may provide information about the impact of the research area upon them.

### *2.3.5 Procedure*

Potential participants were identified and initially approached by a member of the care team asking if they would be interested in participating in a research project. A letter providing a brief summary of the research study was given to each participant approached. Once the potential participants had expressed an interest in taking part in the research and had provided preferred contact details they were sent a participant information sheet and a consent form. The participant information sheet included further details about the research and provided sample questions that may be asked during the interview process.

Giving participants the information in advance provided opportunities for them to ask questions and carefully consider their participation in the study. A stamped address envelope was also enclosed for participants to return the completed consent forms if they wanted to take part in the research. Consent was obtained in accordance with the ethics code of conduct protocol (see ethical consideration section). Once potential participants had returned completed consent forms, the lead researcher contacted them to arrange an interview appointment. The interviews, lasting approximately 60 minutes, were recorded

on a digital audio-recorder. Participants were also debriefed at the end of the interviews; however this was not recorded. In addition participants were reminded that information was available on statutory and local voluntary of agencies of various mental health support services if required. The lead researcher then transcribed verbatim and then with the use of a qualitative data analysis software ATLAS.ti analysed the interviews according to the principles of grounded theory methodology.

#### *2.3.6 Reliability and Validity*

Reliability of the research process was ensured by keeping theoretical memos (see appendix 10). This is important for the grounded theory approach as it ensures that the theory is ‘grounded’ in the data obtained.

To ensure validity of the research measures and procedures all questions in the semi-structured interviews were designed with respect to the direct aims of the research. The interview questions were checked and re-checked by the research team to ensure clinical and research significance.

Within qualitative research three types of errors can be made: i) type 1 error, observing relationships or themes which are not correct, ii) type 2 error, rejecting relationships or themes when they are correct and iii) type 3 error, asking questions which are not valid to the research (Flick, 2002). The risks of type 1 and 2 errors were addressed during the coding and categorising stages as careful measures were applied by checking and rechecking of emerging themes



and formulation of the emerging theory in relation to this. The coding procedures were peer reviewed to ensure any codes overlooked by the lead researcher were then incorporated and included in the research. The possibility of type 3 error in this context was attended to by designing the semi-structured interview questions appropriately to the research aims. The questions were assessed by the research team.

### *2.3.7 Subjectivity in research*

Prior to carrying out the interviews it was important to be mindful of possible interviewer bias. However, the lead researcher valued the role of subjectivity in this research process as the researcher is South Asian. This may have led South Asian participants to have a pre-conception that the lead researcher understood their cultural experiences. The ethnic origin of the lead researcher may have also been of some value in the research process as the experience of a South Asian individual living in a Western country may have been better understood, compared to individuals who have not had this experience. The lead researcher was on placement at the same specialist eating disorder service where the research was carried out. It was therefore imperative to ensure that the lead researcher was not in any way associated in the current or future care of any of the potential participants approached to take part in the research. Working in an eating disorders service enabled the lead researcher to understand the treatments offered to people with eating disorders, and therefore may have aided the interview process when participants had referenced particular treatments they had engaged in. The experience of working with individuals with eating

disorders provided an increase in awareness of multifactorial processes experienced with eating disorders.

## 2.4 Results

Following the analysis of the interviews 21 lower order categories emerged for the South Asian participants and from these 7 higher order categories were identified. For the Caucasian participants 14 lower order codes emerged from which 5 higher order categories were identified. Table 2 illustrates the lower and higher order categories for both South Asian and Caucasian participants Higher and lower order categories are presented in a parallel format to demonstrate some of the emerging themes between the two participant samples.



Table 2: Examples of the lower and higher order categories emerged from the data are shown:

South Asian Women		Caucasian Women	
Higher Order Categories	Lower Order Categories	Higher Order Categories	Lower Order Categories
Adverse Childhood Experiences	Abuse  Emotional upbringing	Adverse Childhood Experiences	Abuse  Emotional upbringing
Effect on Sense of Self	Low self esteem  Poor body image	Effect on Sense of Self	Low self esteem  Poor body image
Accessing Family Support	No support  Uninformed of eating disorder	Accessing Family Support	Supported  Aware of eating disorder
Accessing Treatment	Could not cope  Needed help	Accessing Treatment	Right time  Needed help
Cultural Influences	Rules/Restrictions  Silence		
Negative Consequences of Speaking Out	Fear of being ostracised  Fear of stigma to family		

Once no further categories were identified and saturation of the data was reached a model was then developed (see figure 1). This model offers an interpretation of the participant data collected and the relationship between emerging categories.



Figure. 1. A model illustrating the development and experiences of eating disorders for South Asian and Caucasian women.

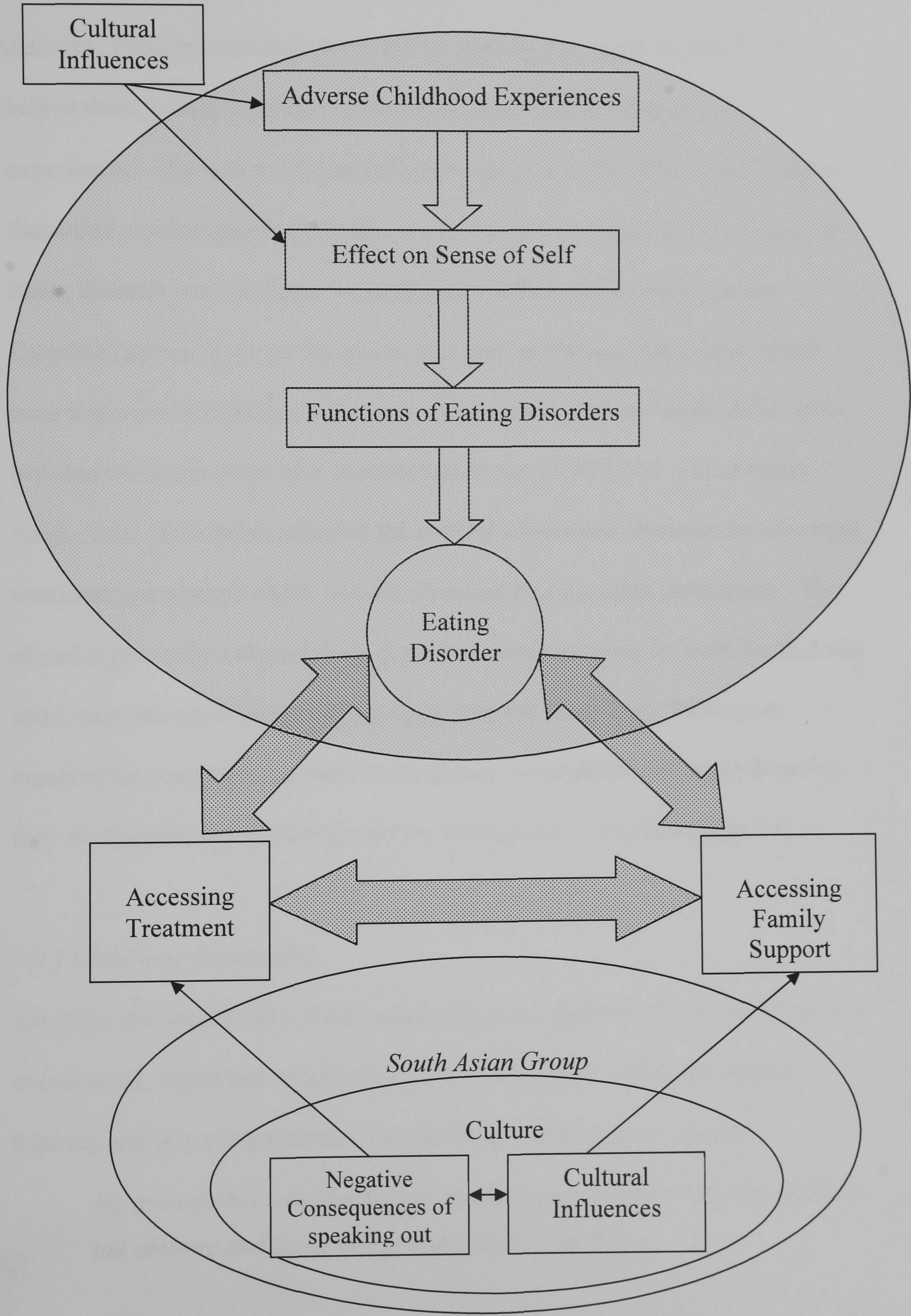




Figure 1 highlights that a causal may be offered for some of the relationships identified for example, various adverse childhood experiences may influence the participants' sense of self. This link may have impacted on the function of the disorder. Participants talked about the function of the eating disorder in that it helped them to cope with their sense of self and some of the negative experiences. The reason why participants presented with eating disorders rather than other psychological presentations is unclear. This pathway to the onset of eating disorder was discussed by participants in both the South Asian and Caucasian groups however the notion that early experiences and sense of self were impacted by respective cultural influences was evident. Some differences between the groups were also identified as shown in the lower part of Figure 1. South Asian participants talked of the cultural effects and obstacles for accessing treatment and support which was not discussed by Caucasian participants. The shared higher order categories are explained simultaneously for both South Asian and Caucasian participants with excerpts from the interviews. Participant numbers have not been included in the quotes to maximise anonymity however they are identified by culture group i.e., South Asian = SA, Caucasian = C.

#### *2.4.1 Childhood Experiences*

All of the participants described various adverse childhood experiences they had encountered, which had contributed to the onset of their eating disordered thinking and behaviour patterns. For instance, one participant stated;

*My grandfather was abusing me sexually you know not have sex with me but abusing and doing things that I didn't like (SA)*

Another participant said;

*When I was younger I was abused by a baby sitter (SA)*

One of the women also told me that;

*Being bullied at school was definitely a major factor (C)*

Along with the abuse, Caucasian participants also highlighted emotional trauma caused by life events, such as parental divorce. For example one woman stated;

*I don't even think I can pin point it down to one thing but there were a lot of things that were coming up like.....my parents getting divorced (C)*

The Caucasian participants also talked of being affected by instability in childhood causing distress and difficulties for example, one woman said that;

*I think originally we had moved house when I was quite young and we moved ..... so I think being up in completely new environment and it was just me and my mum initially and then my brother was born and then it had just been like us three..... and when I had just settled getting into new groups.....I think I didn't handle too well (C)*

#### 2.4.2 Effect on Sense of self

These adverse childhood experiences appeared to have an impact on the participants' sense of self, for example one woman stated that;

*I always felt like that it was because I was not good enough and that I was sort of like suffering from this (C)*



Another woman said that;

*If I wasn't born if I wasn't around then everybody else would have that perfect life I was the imperfect thing in that situation and I was unlovable (SA)*

Participants in both groups also talked of blaming themselves for various life events. They described feeling that they deserved everything that happened to them, one woman said;

*It was me it was my fault whatever was going on that I was the bad person I wasn't the nice one I was useless waste of space and you know I deserved it (SA)*

Participants also described other people noticing changes in their body as they developed and making negative comments and being compared to other relatives. Many women interviewed said that it was in response to these comments that the focus on their own body and negative self image began. One woman stated that;

*I was quite overweight and used to get taunts and called 'Free Willy {the film} one, two and three' and things like that (SA)*

Another woman said that;

*I really have a complex about it and I think elements of feeling unattractive and people noticing the changes in my body (C)*

One of the participants stated that;

*I had comments you know that you're fat. In Asians they say "double bodied" it's just my shape, the way I've been, compared to cousins that are slim compared to what I dress and how I wear my clothes (SA)*

Furthermore, one woman said;

*My parents were always fighting and this affected me but I was always a shadow of my own brother, always compared to him but never good enough (C)*

#### 2.4.3 Function of Eating Disorders

The function eating disorders served was described by participants. For example one woman stated;

*She doesn't really understand it if it's an attention thing but it's not it's a control thing it's something that I have control over when I do it (SA)*

Another woman said;

*I had bulimia and I absolutely hated myself I think food was my source of comfort (SA)*

Furthermore another woman said;

*I couldn't help it, I knew I was hurting my self but I felt I needed it I needed it to help me cope, at the time I didn't know how else to cope (C)*

#### 2.4.4 Accessing Family Support

Analysis of interview data revealed major differences in data in terms of accessing family support. Both samples talked of how important support was in helping them to cope with their difficulties mainly for their eating disorder.

Three of the South Asian sample reported that their families were unaware of their eating disorder and from the two that did tell their family one participant described how she had tried to tell her family but they disregarded it and was instead mocked by her father when she tried to seek help. She said;



*When I did try to tell my family and the GP at that time I did know that I was really underweight but I didn't know that it was a disorder or a disease or a you know whatever and when my father used to then ridicule that and even mock me further, he used to say 'feed her' make me eat food that I didn't want (SA)*

Other South Asian women talked of not being able to tell their family. One woman said;

*but my parents never knew I came here last year 'cos I don't want to worry them (SA)*

Another South Asian woman stated that;

*No, none of my family know that I come here and that I'm going through this and I don't think I could tell them (SA)*

This was in contrast to the Caucasian group who generally talked of being able to tell their family. When they informed their family of the eating disorder they reported positive reactions and support. One woman said;

*With my parents I can speak to both of them. My dad is really understanding and very supportive and completely non-judgemental and he's quite good (C)*

One woman described how her family members were the ones who had noticed that she was experiencing difficulties and had encouraged her to seek help as stated below;

*Yeah, it was them that pointed it out to me to go to the doctor and doing something about it (C)*

One of the Caucasian participants however, talked of being able to tell her family but not being supported by them for her eating disorders as stated;

*I think my family I've never really had the support from my family not because they're not supportive but we're really strong good family but I think people feel guilty, parents feel guilty and my sister and brother I don't think they really want to know about it I think it upsets them (C)*

#### 2.4.5 Accessing Treatment

The South Asian participants talked of accessing help for their eating disorder when the illness reached a point where they could not cope alone anymore.

One woman stated;

*With my eating disorder has got to a point where I was regularly I mean you live with it for so long and then you kind of get to a point of desperation where you can't deal with it anymore and I got to a point of desperation where I couldn't live with it anymore (SA)*

The Caucasian participants on the other hand generally described accessing treatment when the time was right for them. When asked in hindsight if she would have sought treatment earlier, one woman said;

*I think it was the right time because it wasn't a major issue before (C)*

#### 2.4.6 Cultural Influences

All of the South Asian participants repeatedly talked of cultural influences, which they had unfavourably been affected by in conjunction with the symptoms of eating disorders. In comparison, the Caucasian participants did not make reference to any cultural influences in the interviews. For example one South Asian woman told me;



*Every time you wanted to that you felt like that you were told that you were betraying your family and you can't do that Asians don't betray the family you don't you keep whatever is in the house in the house you sweep it under the carpet you keep your mouth shut until you die with that secret (SA)*

Another South Asian woman said;

*It's that whole Indian attitude about if you don't think about it or you don't talk about it then it's not there everything's okay and its not like that in some ways it can make things worse because it's quite hurtful because everyone is dismissive about how you feel and how you are (SA)*

The excerpts from interviews shown above highlights the cultural influences within these influences a mixture of restrictions and culture 'silence' were identified causing further obstacles in accessing treatments services.

As a result of the cultural experiences various negative consequences of not adhering to the cultural influences were identified. These negative consequences seemed to restrict the South Asian participants from speaking out about their eating disorders with family members. For example, one woman said;

*I'm not a good daughter and so I just wouldn't go to my GP I just couldn't go to my GP because I thought 'oh my god he's gonna tell my mum and dad' and I didn't want it on my records because of the stigma attached and the rest of it within the Indian community so I didn't (SA)*

The South Asian participants identified some negative experiences of the specialist eating disorder service therapy that were due to cultural differences within the group for example one woman stated;

*like I said Indians come as a family unit and not as an individual and how you grow up is about family like I said before I don't dislike that but in terms of the advice that you were given in the recovery group sometimes its very difficult to follow that advice (SA)*

## 2.5 Discussion

The aim of this research was to examine the factors influencing the onset of eating disorders in South Asian women and to explore the similarities and differences in their experience of eating disorders as compared with their Caucasian counterparts. A model of the experience of eating disorders in the two groups is proposed and illustrated in figure 1.

Analysis of the interviews of both groups showed many similarities in the early experiences for risk factors and triggers to eating disorders for both South Asian and Caucasian participants, which supports the findings of previous research (see, Mitchell and Mazzeo, 2004; le Grange, Telch and Agras, 1997; le Grange, Stone and Brownell, 1998; Haudek, Rorty and Barbara, 1999; Williamson, Sedula, Anda, Levy and Byers, 1992). However, along with the shared experiences of the South Asian women and their Caucasian counterparts an additional category emerged from the data analysis. This category was the influence of culture for South Asian women. Data analysis revealed South Asian culture plays an important role in the maintenance of eating disorders contributing to difficulties in accessing family and treatment support. The category included culture restrictions, rules and expectations of family and culture.



The fear of people especially family members finding out about their eating disorders was evident from interviews with the South Asian women. This group talked about the consequences of the South Asian community finding out as mental health difficulties appear to have a stigma attached. They were in conflict with 'culture silence' and eating disorder distress resulting in feelings of loneliness and isolation. Those South Asian women who had attempted to tell their family were told to stay quiet and not talk about their eating disorder and experiences of abuse. Others were afraid of negative labelling and shame being brought upon the family if their eating disorder was disclosed to the community. In this way the interviews highlighted the cultural pressure which forms as an obstacle for South Asian women to accessing eating disorder services and support and may result in individuals from this community feeling isolated and alone.

Liebling, Chipchase and Velangi (1997) suggested that women who self-harm in secure settings experience isolation and exclusion further contributing to psychological distress which in turn heightens the risk of attempted suicide or self-harm. If South Asian women are less likely to access treatment for eating disorders during mild to moderate stages of the disorders and are more likely to present to services during acute and chronic stages of the disorder, by the time they access services they may require in-patient care, further adding to their feelings of isolation and exclusion from family members and their ethnic community. It is therefore important to identify possible ways to help address these obstacles for South Asian women, as NICE (2004) recommended that

individuals with eating disorders should be assessed and treated at the earliest opportunity.

When providing service feedback during the interviews the South Asian group had stressed the lack of information about eating disorders. Consequently some had not known that they were suffering with this disorder until it was highlighted by their General Practitioners (GP). Many participants in the South Asian group talked of their reluctance of seeking help from their GP in case their GP breeched confidentiality and their family members were informed of their eating disorder. This supports the proposal by Vlassoff (1994) who suggested that in many developing countries women often complain about the lack of confidentiality, privacy and information about the services available.

South Asian women interviewed described being compared to their “slimmer and more attractive” family members and described how this encouraged them to try and lose weight. These findings do not support Wildes, Emery and Simons’ (2001) research, which suggested that pressures to be thin from friends and family members did not impact on the development of anorexia and bulimia nervosa.

The samples of participants interviewed were individuals who had voluntarily accessed help and attended an eating disorders service. It was only due to their attendance at screening appointments that they were then diagnosed. Those women who do not access services, particularly South Asian women



remain undiagnosed, without support due to cultural barriers and lack of knowledge in current services. It is therefore difficult to establish an accurate estimate of the prevalence of eating disorders, and as a result the prevalence rates are an underestimate. However, this difficulty is not culture specific.

Self-harming behaviours among people with eating disorders have been associated with early histories of abuse (Fullerton, Wonderlich, & Gosnell, 1995). Various forms of abuse (physical, verbal and sexual) and childhood neglect were described by both groups taking part in this study. This supports previous findings that there may exist a causal relationship between abuse and eating disorders (Sanci, Coffey, Olsson, Reid, Carlin & Patton (2008); Smolak & Murnen, 2002), although the research in this area tends to be inconsistent.

Phinney (1993) suggested that the development of ethnic identity begins in childhood and takes shape during early adulthood. The participants all identified that the onset of eating disorders occurred during teenage years. The participants discussed that the process of identity development coincided with the onset of eating disorders. For the South Asian participants ethnicity may have contributed to the onset of eating disorders during their adolescence as they manage the differences in concepts of beauty ideals in the South Asian culture and the majority environmental white Western culture. This is in line with Phinneys (1993) findings that ‘culture conflict’ is a risk factor for eating disorders.

Overall the findings of this research suggest that South Asians and Caucasians have similar pathways and risk factors for the onset of their eating disorders. However, substantial differences between the two cultures are observed when accessing support from family members and treatment services. This latter finding contrasts with the research by Ogden and Elder (1998) and Cachelin, Rebeck, Veisel, and Striegel-Moore (2001) who reported that no relationship was found between ethnic identity and treatment seeking. Analysis of current research data indicates that women from ethnic minority groups are more likely to remain undiagnosed and therefore untreated order in comparison to Caucasian women (Cachelin & Striegel-Moore, 2006). The current study identifies one of the factors which explains the reasons for this as the important influence of culture and resulting lack of support.

## 2.6 Methodological limitations

The results reported in this research should be interpreted with caution due to a number of methodological limitations. Participants were recruited through a means of availability. A small number of South Asian people had received input from the Eating Disorders Service and therefore the initial sample size for potential participants was small, this sample size was further reduced once the inclusion and exclusion criteria were applied. To allow the focus of the South Asian participants to remain prominent, the Caucasian group was restricted to the same number as the South Asian group.



If a larger sample size was available the results may have more clearly identified similarities and differences between the two sample groups. The sample consisted of people diagnosed with anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified. It may have been useful to have an equal number of participants from each diagnostic category.

The question arises as to whether the findings would have been similar if the interviews and analysis were carried out by a Caucasian researcher rather than by a South Asian researcher. It may have been that the South Asian participants discussed difficulties within the cultural realm on the assumption of increased awareness and understanding by the lead researcher of their particular circumstances. It was evident that participants thought that the lead researcher understood their culture. For example, participants made comments in Hindi, a popular South Asian language, such as, “*Jadoo*” which means black magic or making references to “*our culture*” and “*you know what I mean*”.

Although the ‘South Asian’ definition used in this research was people of Indian, Pakistani, Bangladeshi and Sri Lankan origin no Sri Lankan participants were available for the research. There is a possibility that a higher number of differences were not found due to the limitations of carrying out an interview for example interviewer bias. The possibility of supporting the methodology by including a questionnaire regarding various risk factors and needs may have provided further valuable information about the ‘journey’ with eating disorders that individuals from different ethnic groups go through.

The matching of participant's age and diagnosis was intended for the two groups. The mean age for the South Asian participants was greater than the mean age of the Caucasian sample. It was also observed that all five of the South Asian participant had a diagnosis of EDNOS whereas four of the participants from the Caucasian sample had a diagnosis of Bulimia Nervosa and one was diagnosed with EDNOS. This supports the analysis by Fairburn and Brownell (2002) who found that the diagnosis of EDNOS appears to be more common in ethnic minorities than anorexia nervosa and bulimia nervosa. It is important to note that it may have been that only South Asians with a diagnosis of EDNOS chose to agree to take part in the research. Although much was done to match participants in terms of age and diagnosis this proved difficult given the selection criteria that were established for the study. From the potential participants it was noted that more Caucasian individuals were diagnosed with Bulimia nervosa and more South Asian individuals were diagnosed with EDNOS. This may have contributed to the difficulty in matching the two samples.

Due to the limitations discussed here, the results and model developed cannot be generalised to the greater population and it should be emphasised that the results are an interpretation of the data from the interviews from the current research.



## 2.7 Clinical implications and Recommendations for future research

Mental health practitioners may be more familiar with the experiences of Caucasian people with eating disorders. The current findings demonstrate that although the similarities are present between Caucasian and South Asian groups, various cultural obstacles may have deterred South Asians from accessing support. Therefore, the South Asian group may have experienced the disorder for long periods of time without having disclosed their difficulties to anyone. As a result of this clinical interventions may need to be applied more sensitively and over longer periods of time. This study helps practitioners understand that South Asian individuals encounter a variety of cultural difficulties that prevent them from accessing support and which continue when accessing eating disorder services. In particular the belief that mental health difficulties are not acceptable in the South Asian culture influences their ability to disclose their difficulties. The results of this research suggest further training and supervision in cultural diversity issues would help mental health clinicians in eating disorder services to increase their understanding of the cultural issues that South Asian and other ethnic minority individuals may experience. As family support was identified as a barrier for South Asian women accessing services, eating disorder service clinicians need to help increase the awareness of the disorder in this cultural group.

As a follow up to the current study, it would be useful to research the experiences of the family members of individuals with eating disorders. It may be a lack of understanding of the disorder as well as cultural factors that hinders

cultural acceptance of eating disorders difficulties thus impacting on the level of support offered. It is appreciated however that this may be difficult due to the number of families that are aware of their family member's eating disorder. However, a qualitative approach would assist to identify an in-depth understanding of these issues and to explore what has assisted women to disclose their difficulties

The current research identifies the needs of South Asian women. However, there may be differences between South Asian cultures for example, individuals from an Indian culture may encounter different experiences with eating disorders than individuals from a Pakistani culture. Further research on the similarities and differences of eating disorders in specific cultures would help to inform clinical practices.

As the current research has identified 'cultural stigma' towards mental health difficulties as a deterrent for accessing treatment for South Asian women raises a question about the difficulty for South Asian men of disclosing an eating disorder and the underlying reasons for this. This would also be an area worthy of future research.



## 2.8 References

- Allison, D. B. (1995). *Handbook of assessment methods for eating behaviours and weight related problems: measures, theory and research*. London: Sage.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Anand, A. S., & Cochrane, R. (2005). The Mental Health Status of South Asian Women in Britain: A review of the UK Literature. *Psychology and Developing Societies*, 17(2), 195-214.
- Billiappa, J. (1991). *Illness or Distress? Alternative Models of Mental Health*, Confederation of Indian Organisations.
- Button, E. J., Sonuga-Barke, E. J. S., Davies, J., & Thompson, M. (1996). A prospective study of self-esteem in the prediction of eating problems in adolescent schoolgirls: Questionnaire findings. *British Journal of clinical Psychology*, 35, 193-203.
- Bhugra, D., & Bhui, K. (2003). Eating Disorders in teenagers in East London: A survey. *European Eating Disorders Review*, 11, 46-57.
- British Psychological Society (2006). Code of ethics and Conduct. Retrieved March 24, 2006, from [www.bps.org.uk/the-society/code-of-conduct/code-of-conduct\\_home.cfm](http://www.bps.org.uk/the-society/code-of-conduct/code-of-conduct_home.cfm)

- Burman, E., Chantler, K., & Batsleer, J. (2002). Service responses to South Asian women who attempt suicide or self-harm: challenges for service commissioning and delivery. *Critical Social Policy* 22 (4). 641-668.
- Cachelin, F. M., Rebeck, R., Veisel, C., & Striegel-Moore, R.H. (2001). Barriers to treatment for eating disorders among ethnically diverse women, *International Journal of Eating Disorders*, 30, 269–278.
- Cachelin, F. M., & Striegel-Moore, R. H. Help seeking and barriers to treatment in a community sample of Mexican American and European American women with eating disorders. *International Journal of Eating Disorders*, 39, 1544-161.
- Cash, T.F., Winstead, B.W., & Janda, L.H. (1986). *The great American shape-up: Body image survey report. Psychology Today*, 20(4), 30-37.
- Castro, V.S. (2003). *Acculturation and psychological adaptation*. Westport, CT: Greenwood Press.
- Census UK (2001). Office for National Statistics Retrieved February 17, 2008, from [www.statistics.gov.uk/census2001/](http://www.statistics.gov.uk/census2001/)
- Charmaz, C. (2000) Grounded Theory: Objectivist and Constructivist Methods. In Denzin, N. & Lincoln, Y. (Eds.) *Handbook of Qualitative Research*. 2nd ed. London: Sage.
- Cooper, P. J., & Fairburn, C. G. (1983). Binge eating and self-induced vomiting in the community: A preliminary study. *British Journal of Psychiatry*, 142, 139–144.



Crago, M., Shisslak, C. M., & Estes, L. (1996). Eating disorders among American minority groups: A review. *The International Journal of Eating Disorders*, 19(3): 239-248.

Department of Health –Delivering Race and Equality: A framework for action  
October 2003. Retrieved November 12, 2006, from  
<http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH>

Fairburn, C. G., Cooper, Z., Doll, H. A., & Welch, S.L. (1999). Risk factors for anorexia nervosa: Three integrated case control comparisons. *Archives of General Psychiatry*, 56, 468-476.

Fairburn, C. G. & Harrison, P. J. (2003) Eating disorders. *Lancet*, 361, 407 -416.

Flick, U. (2002). An Introduction to Qualitative Research. 2nd ed. London: Sage.

Fullerton, D.T., Wonderlich, S. A., & Gosnell, B. A. (1995). Clinical characteristics of eating disorder patients who report sexual or physical abuse, *International Journal of Eating Disorders*, 17, 243–249.

Furnham, A., & Calnan, A. (1998). Eating disturbances, self-esteem, reasons for exercising and body weight dissatisfaction in adolescent males. *European Eating Disorders Review*, 6, 58–72.

Garner, D.M. (1990). *Eating Disorder Inventory–2 professional manual*. Odessa, FL: Psychological Assessment Resources.

Garner, D.M., & Garfinkel, P.E. (1979). The Eating Attitudes Test: an index of the symptoms of anorexia nervosa. *Psychological Medicine*, 9, 273-279.

Geraghty, R., & Warren, F. (2003). Ethnic diversity and equality of access to specialist therapeutic community treatment for severe personality disorder. *Psychiatric Bulletin*, 27, 453-456.

Gilbert, P., Gilbert, J., & Sanghera, J. (2004). A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby. *Mental Health, Religion & Culture*, 7(2), 109-130.

Hall, C.C. (1995). Asian Eyes: Body Image and Eating Disorders of Asian and Asian American Women. *Eating Disorders*, 3(1), 8-19.

Haudek, C., Rorty, M., & Barbara, H. (1999). The role of ethnicity and parental bonding in the eating and weight concerns of Asian-American and Caucasian college women. *International Journal of Eating Disorders*, 25(4), 425-433.

Haworth-Hoeppner, S. (2000). The Role of Culture and Family in the Production of Eating Disorders. *Journal of Marriage and Family*, 62(1), 212-227.

Henderson, M., & Freeman, C. P. (1987). A self-rating scale for bulimia: the 'BITE'. *British Journal of Psychiatry*, 150, 18 -24.

Hesse-Biber, S., Marino, M & Watts-Roy. (1999). A Longitudinal study of eating disorders among college women. *Gender & Society*, 13(3), 385-408.



Hewitt, P. L., Flett, G. L., & Ediger, E. (1995). Perfectionism traits and perfectionistic self-presentation in eating disorder attitudes, characteristics, and symptoms. *International Journal of Eating Disorders, 18*, 317-326.

Hindmarch, T. (2000). *Eating Disorders: A Multiprofessional approach*. London: Whurr.

King, M.B. (1993). Cultural aspects of eating disorders. *International Review of Psychiatry 5*, 205-216

Kuba, S. A., & Harris, D. J. (2001). Eating disturbances in women of color: An exploratory study of contextual factors in the development of disordered eating in Mexican American women. *Health Care for Women International, 22*, 281-298.

Lachenmeyer, J. R., & Muni-Brandner, P. (1988). Eating disorders in a non-clinical adolescent population: Implications for treatment. *Adolescence, 23*(90), 303-312.

Lake, A.J., Staiger, P.K., Glowinski, H. (2000). Effect of Western Culture on Women's Attitudes to Eating and Perceptions of Body Shape. *International Journal of Eating Disorders, 27*(1), 83-89.

Lee. S., & Katzman. M. A. (2002). Cross-cultural perspectives on eating disorders. In C. G.Faiburn, & K. D. Brownell (Eds.), *Eating Disorders*

Eating disorders in South Asian women: A comparative analysis of underlying reasons,  
needs and service implications

and Obesity: a Comprehensive Handbook, (2<sup>nd</sup> ed.), pp. 260-293.

Guilford Press, New York.

le Grange, D., Stone, A.A., & Brownell, K.D. (1998). Eating disturbances in white and minority female dieters. *International Journal of Eating Disorders*, 24(4), 395-403.

le Grange, D., Telch, C. F., & Agras, W. S. (1997). Eating and general psychopathology in a sample of Caucasian and ethnic minority subjects. *International Journal of Eating Disorders*, 21(3), 285-293.

Liebling, H., Chipchase, H., & Velangi, R. (1997) 'Why Do Women Harm Themselves? Surviving Special Hospitals'. *Feminism & Psychology* 7(3): 427-37.

Marshall, H., & Yazdani, A. (2000). *Young Asian women and self-harm*. In J.M. Ussher (Ed.), *Women's health: Contemporary international perspectives* (pp. 59–69). Leicester: BPS Books.

Maj, M., Halmi, K., Lopez-Ibor, J. J., & Sartorius. (2003). *Eating Disorders*. Chichester: Wiley.

McComb, J.J. (2001). *Eating Disorders in Women and Children: Prevention, Stress Management, and Treatment*. London: CRC.

McCourt, J., & Waller, G. (1996). The influence of sociocultural factors on the eating psychopathology of Asian women in British society. *European Eating Disorders Review*, 4(2), 73-83.



- Mitchell, K.S., & Mazzeo, S.E. (2004). Binge eating and psychological distress in ethnically diverse undergraduate men and women. *Eating Behaviours*, 5, 157-169.
- Mumford, D. B., 1993. Eating disorders in different cultures. *International Review of Psychiatry*, 5, 109-114.
- Mumford, D. B., Whitehouse, A.M., & Platts, M. (1991). Sociocultural correlates of eating disorders among Asian schoolgirls in Bradford. *British journal of Psychiatry*, 158, 222-228.
- MIND. (1993). National Association for Mental Health. Mind's Policy on Black and Minority Ethnic Groups and Mental Health. Retrieved March 8, 2008, from <http://www.mind.org.uk/Information/Factsheets/Diversity/MHSACB.htm>
- MIND. (2006). National Association for Mental Health. Men and Mental Distress. Retrieved March 8, 2008, from <http://www.mind.org.uk/Information/Factsheets/Men/>
- NICE (2004) The National Institute for Clinical Excellence and Mental Health National Institute for Clinical Excellence. (2004). Eating Disorders- Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. Author.

Ogden, J., & Chanana, A. (1998). Explaining the effect of ethnicity on weight concern: Finding a role for family values. *International Journal of Obesity*, 22, 641–647.

Oxford dictionary. (2008). Oxford: Oxford University Press

Phinney, J. (1993). A three-stage model of ethnic identity development. In M. Bernal and G. Knight (Eds.), *Ethnic identity: Formation and transmission among Hispanics and other minorities*, (pp. 61-79). Albany: State University of New York Press.

Radia, K. (1996) *Ignored, Silenced, Neglected – Housing and mental health care needs of Asian people in the London Boroughs of Brent, Ealing, Harrow and Tower Hamlets*.

Rayar, O & Davies, J. (1996). Cross-cultural aspects of eating disorders in Asian girls. *Nutrition & Food Science*, 96(4), 19-22.

Ritenbaugh, C., Shisslak, C., & Prince, R. (1992). *Eating disorders: a cross-cultural review in regard to DSM-IV*. In: *Cultural Proposals for DSM-IV*. Mezzich JE, Kleinman A, Farga H et al., eds. Submitted to the DSM-IV Task Force by the NIMH Group on Culture and Diagnosis. Pittsburgh: University of Pittsburgh.

Sanci, L., Coffey, C., Olsson, C., Reid, S., Carlin, J. B., & Patton, G. (2008). Childhood Sexual Abuse and Eating Disorders in Females. *Archives of Pediatrics & Adolescent Medicine*. 162(3), 261-267.

Patton, G.C., Coffey, C., Carlin, J.B., Sanci, L., & Sawyer, S.M. (2008). Prognosis of adolescent partial syndromes of eating disorder. *British Journal of Psychiatry*, 192, 294-299.



- Smolak, L, & Murnen, S. K. (2002). A meta-analytic examination of the  
*relationship between child sexual abuse and eating disorders.*  
*International Journal of Eating Disorders*, 31, 136-150
- Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Grounded theory  
procedures and techniques.* Newbury Park, CA: Sage.
- Strauss A, Corbin J (1998) *Basics of Qualitative Research. Techniques and  
Procedures for Developing Grounded Theory.* 2nd ed. Newbury Park,  
Sage.
- Striegel-Moore, R.H., Wilfley, D.E., Pike, K.M., Dohm, F.A., & Fairburn, C.G.  
(2002). Recurrent binge eating in black American women. *Archives of  
Family Medicine* 9,83-87.
- Striegel-Moore, R. H., & Smolak, L. (2002). Gender, ethnicity and eating  
disorders. In C. G. Fairburn & K. D. Brownell (Eds.), *Eating disorders  
and obesity 2nd ed.* (pp. 251-255). New York: Guilford Press.
- Vlassoff, C. (1994). Gender inequalities in health in the Third World: uncharted  
ground. *Social Science & Medicine*, 39, 1249-1259.
- Wildes, J. E., Emery, R. E., & Simons, A. D. (2001). The roles of ethnicity and  
culture in the development of eating disturbance and body dissatisfaction:  
A meta-analytic review. *Clinical Psychology Review*, 21(4), 521-551.
- Williamson, D.F., Sedula, M.K., Anda, R.F., Levy, A., & Byers, T. (1992).  
Weight loss attempts in adults: goal duration, rate of weight loss.  
*American Journal of Public Health*, 82, 1251-1257.

## **Chapter 3: Reflective Paper**

# **Minority Groups and Eating Disorders: A reflective account**

Word Count (excluding references 2512)



### 3.1 Introduction

This paper will reflect on my experiences throughout the research process. My literature review was carried out on men and eating disorders and also explored various gender similarities and differences. My empirical paper examined the experiences of South Asian women with eating disorders and researched the similarities and differences of their experiences to Caucasian women with eating difficulties. In this reflective paper, I will discuss why I chose this research area, the methodological issues, my personal and professional development and directions for future research, including clinical implications.

### 3.2 Research area

According to Wilkinson (1988), personal reflexivity is important in evaluating qualitative research. This process is carried out by identifying the impact of researcher bias on the study. The idea for my research evolved over a number of years, right from the onset as a support worker, carried into my posts as an assistant psychologist and continuing into my clinical psychology training. I have been intrigued by the factors that help and also deter individuals to access mental health services. As an ethnic minority individual I was often asked questions about my Indian culture by colleagues. This situation would mainly arise when colleagues had clients from the same or similar cultural background to me and I found that in many ways I was providing peer supervision.

My interest in 'gender labelling' of mental health difficulties arose during my work as an Assistant Psychologist as I co-facilitated groups for people experiencing difficulties with anger. I was interested in the high number of men

and the fewer number of women that presented to the service with anger problems. Women in the group talked of anger being a socially unacceptable emotion for them whereas men talked of being more comfortable with disclosing to others that they had difficulties with anger. During my first year placement induction I met a clinician working in a specialist eating disorder service in a small town in Warwickshire. She talked about the difficulty in trying to reach out to men and also the particular problems ethnic minorities with eating disorders encounter, she also explained that her experience of working with these population groups was limited. We discussed and attributed this to the possibility of the town that she was working in being less culturally diverse. This however, did not explain why men were not attending the eating disorders service. This clinician was interested in making the service more accessible to men as well as to individuals of various ethnic communities. The clinician also asked if she could contact me for advice regarding the South Asian culture as she thought this would help her to understand where this group may go for help with their eating disorder if they do not access mental health services. I went on to see if this was a similar experience for other services specialising in eating disorders and found that they encountered the same, few men and few ethnic minorities accessing services. These reasons increased my interest in these areas.

### 3.3 Approaching participants

The process of approaching the participants was carried out by following ethical recommendations of a former or current member of the care team asking the potential participants if they would like to take part in the research prior to any contact by the researcher was made. As a result of this process there may have



been some bias in the recruitment stage. The potential participants may have felt inclined to agree to take part in the research. However, appropriate measures were carried out prior to the interview informing the participants that participation or refusal to participate would not impact in any way to the care that they were receiving from the service. The fact that participants were approached by people that they were familiar with may have also felt less overwhelming and more comfortable for them rather than being asked by a complete stranger.

### 3.4 Methodological issues

I was aware that trying to recruit South Asian participants would be difficult and therefore had chosen a culturally diverse city to carry out the research, in the hope that this limitation would be minimised. I found that approximately twenty South Asian women and over five-hundred Caucasian women had been referred to the eating disorder service in the past five years. However, not all the twenty South Asian women had attended appointments, some had not attended the appointments offered at all and a few had attended the first appointment and then later did not attend. A few of the South Asian participants had a request on their file that they did not want to be contacted by correspondence at home and could only be contacted by their mobile telephone, however in some instances these mobile numbers were no longer active. This further reduced the number of potential South Asian participants. As I encountered ongoing difficulties during the recruitment stages of the research I did wonder why I had chosen a research topic that was so hard to carry out at the onset, however I knew deep down that this is what I wanted to research and therefore rose to the challenge.

I decided to choose grounded theory for my approach because I knew that to understand and explore the participant's experiences I did not want to impose any opinions or biases and I wanted to let the participants have control and decide what they wanted to tell me in a semi-structured way. This was discussed with my academic supervisor and grounded theory was thought to be the appropriate theory to use as this is a "bottom-up" approach that allows theory to emerge directly from the participants' interviews.

The use of clinical samples in research with eating disorders with ethnic minorities is limited and I had the opportunity! I wanted to take this opportunity and allow a model to evolve from their data. On reflection I do think that the research may have benefited from a mixed design by using both qualitative and quantitative method to study this area. Using standardised questionnaires used regularly by clinicians working with individuals with eating disorders such as the EDI and the EAT may help to ascertain whether screening tools for the disorder are culturally sensitive for the participants that took part in the research or whether supplementary questions are required to aid the diagnostic screening process for eating disorders.

### 3.5 Interviews

Transcribing interviews was a valuable experience for me. I learnt about when to stop. As I am a moderately slow typist transcribing took a long time. I wanted to transcribe all of the ten interviews myself and knew I had hours and days of work ahead of me. The reality of it was that it took weeks. It was not only the transcribing that was a process I had engaged in but it was also a process of



listening to interviews in which participants had shared some difficult experiences such as, abuse. After listening to the interviews not only once but having to listen over and over again while typing each detail out was very difficult. I knew I had a tight schedule to transcribe as my research schedule had already been delayed by the difficulty with recruitment but eventually the process of transcribing had to be slowed down. I had supervision with my clinical supervisor to discuss the impact the interviews had on me and I had to make sure I looked after myself through the process of the research.

### 3.6 Ethnicity

Interviewing people from the same ethnic community had its advantages and disadvantages. One of the advantages was that I have some understanding of the various cultural issues that the South Asian participants talked about for example, older South Asian generations may have a limited understanding of psychological difficulties. It is difficult to explain the concept of psychological difficulties and to describe the services available to South Asian people who do not speak English. There is no exact translation of psychology in the South Asian languages for example, the closest translation of psychological services in the popular South Asian language, Hindi is 'pagaal kanna' which means 'mad house'. This in turn has consequences of stigma and labelling attached for South Asians with mental health problems. The disadvantage of being from the same Ethnic community is two-fold. Firstly, South Asian participants may assume that I can associate with their cultural experiences and therefore may have either over-emphasised their cultural experiences with the expectation that I may respond or they may fear that I may breach confidentiality in some way and their

difficulties will be known to the community. Secondly, as a South Asian I was at risk of contaminating the research with my own cultural beliefs and experiences. These disadvantages were appropriately addressed to ensure validity and reliability.

### 3.7 Validity and Reliability

Qualitative research is not value free and I was conscious of wanting to protect the data from my biases. Although there are some biases which may be less controlled it was important to be aware of them throughout the research process and attempt to not influence the data by them as much as possible. Researchers using grounded theory differ in the amount of raw data they include in the results (Charmaz, 1995) it was therefore important to consult with supervisors to ensure that the data included was emergent from the data and not directed by my values and biases. I took measures to reduce bias by checking and rechecking my data to ensure that the model had emerged from the data and not from my values and biases. I kept a research diary to help write down some of the thoughts and biases I had about the research prior to carrying out the study and continued to use the diary to write about the emotions I was experiencing throughout the research. This process helped me to separate my perceptions to that of the participants which therefore enabled the research model to emerge from the data as per the process of grounded theory. To ensure that I did not influence the interview process I responded in a neutral manner ensuring that I was not guiding the participant's responses in any way.



I ensured that throughout the research process I collaborated with my research and clinical supervisors. I also ensured that the coding and categorising process was peer checked to ensure that my interpretation of the data was kept neutral as possible.

### 3.8 Personal reflections

Embarking on a career in clinical psychology has been exciting but also difficult. I was the first person in my family to embark on a career in Clinical Psychology and coming from a family who although did not oppose to psychology, some extended family members were slightly reluctant about the profession as they did not know much about it and so wanted to encourage me to take up a Pharmacy degree. Being the only child I felt a slight pressure to conform to the expectations of the extended family but I was lucky that my parents supported me through my choice of profession. Over the years now I have seen a shift in the way my extended family view mental health. They talk more openly about it and seem to have a better understanding of what mental health services can offer to help individuals regardless of gender or ethnicity is rewarding.

### 3.9 Reflexivity and Values

As I attempted to be as objective as possible I valued the importance of reflexivity and followed the process of personal, functional and disciplinary reflexivity as recommended by Wilkinson (1988). Acknowledgement that a researcher and the research cannot be value-free is pertinent in evaluating the research findings (Bannister, 1999). It is important for Psychologists to be aware of the impact of their values, beliefs and limitations upon their work (American

Psychological Association, 1992) and rather than try to conceal the values the researcher should make them explicit (Harré, 1979). The impact of my values and limitations has been discussed in this research thesis.

### 3.10 Recommendations from the research findings

One of the recommendations made by the South Asian participants was that the service should be more aware of South Asian cultures but how should the clinicians do this? Surely even within the South Asian groups there are various different sub-cultures and norms so how can the services cater for these cultures? From the research findings we know what we are recommended to do but how we should do this remains unclear. Also the suggestion made by the participants of re-evaluating the group sessions to be aware of cultural limitations and rules may not be feasible in certain circumstances. It may be the case that more training and support in cultural diversity issues help to make services more accessible and help individuals from ethnic minorities feel more understood.

It was quite heartfelt to know that there were people who had suffered in silence; they had never told anybody about their abuse or their eating disorder difficulties. To know that the service may have been the first place they had confessed how they were feeling and what they had gone through was difficult. To know that some people were suffering in silence to protect their parents and siblings from the negative stigma their culture holds for psychological disorders and treatment was very powerful.



The first port of contact for service users in both cultures to gain access for help with their difficulties is hard. This first contact is such a hurdle to overcome and made me a little angry when I heard of negative experiences during these times such as GP not recognising a person's distress and minimising a person's eating pattern. Some service users show such motivation and resilience to seek help therefore persist against the social stigma and the various obstacles they may face during access. But how about those people who do not have that resilience? Where do they go to seek help? Do they go anywhere else? How do they cope? These are questions which would help research in this area further. On reflection there were also some questions that would have been useful to ask individuals who participated in the current research such as where would you have gone if you were unable to have therapy from this service? Who would you have spoken to? What do you think would have happened to your eating disorder? An understanding of the experience of both cultures and genders if they cannot access appropriate psychological help is interesting. How much longer can they suffer in silence and have this 'hidden' disorder?

We have already established that men encounter many obstacles in accessing therapy for eating disorders as do ethnic minorities groups we can only therefore assume that the obstacles are doubled for ethnic minority men with eating disorders.

### 3.11 Conclusion

The process of carrying out this doctoral research and writing the papers has been an important learning curve for me. The process has provided an

experience of understanding the various research issues which need to be considered and an acknowledgement of learning outcomes of each stage need to be identified. These two chapters have increased my understanding not only of what may help guide people to access services but also what the various obstacles might be that deter people from accessing eating disorder services. With an understanding of obstacles, the research has helped me to appreciate what services users may have experienced when attending services and also what the possible reasons for not attending appointments are.



## Appendix 1

### DSM IV Eating Disorders p539-p550

#### Diagnostic criteria for 307.1 Anorexia Nervosa

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
- B. Intense fear of gaining weight or becoming fat, even though underweight.
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self evaluation, or denial of the seriousness of the current low body weight.
- D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration).

#### Diagnostic criteria for 307.51 Bulimia Nervosa

- A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
  - (1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
  - (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

- B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induce vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting or excessive exercise.
- C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.
- D. Self-evaluation is unduly influenced by body shape and weight.
- E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

### 307.50 Eating Disorders Not Otherwise Specified

The Eating Disorders Not Otherwise Specified category is for disorders of eating that do not meet the criteria for any specific Eating Disorder. Examples include:

1. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.
2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current is in the normal range.
3. All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
4. The regular use of inappropriate compensatory behaviour by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies).
5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
6. Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviours characteristic of Bulimia Nervosa.



## Appendix 2: National Research Ethics Service Letter of Approval

05 July 2007

## Warwickshire Research Ethics Committee

Accredited by UKECA to review Type 3 MREC Applications

Miss Bhavisha Dave  
Trainee Clinical Psychologist  
Universities of Coventry & Warwick  
Clinical Psychology  
Room JSG24, James Starley Building  
Priory Street, Coventry  
CV1 5FB

Lewes House  
George Eliot Hospital  
College Street  
Nuneaton  
Warwickshire  
CV10 7DJ

Tel: 02476 865244  
Fax: 02476 865264  
pat.horwell@geh.nhs.uk

Dear Miss Dave

**Full title of study:** South Asian women and eating difficulties;  
underlying reasons, needs and service implications.  
**REC reference number:** 07/H1211/78

The Research Ethics Committee reviewed the above application at the meeting held on 27 June 2007. Thank you for attending to discuss the study.

### Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
Application	1	04 June 2007
Investigator CV		18 May 2007
Protocol	1	11 June 2007
Peer Review		18 April 2007
Questionnaire	1	22 May 2007
Participant Information Sheet: Patient	2	22 May 2007
Participant Consent Form: Patient	2	22 May 2007
CV Dr. Helen J Leibling		
CV Ken Goss		19 February 2005
Coventry University Ethics Committee approval		04 June 2007

### Provisional opinion

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

The Committee asked questions about the following issues to which you gave satisfactory answers :

- PIS - Limits of Confidentiality paragraph 9 - requires specific information on who to contact and contact details - explain in full

Warwickshire Research Ethics Committee is an advisory committee to West Midlands Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within

the Health Research Authority and Research Ethics Committees in England



- Clarification of the logistics of how patients are approached and the purpose of the study
- Explanation of the reason behind using a South Asian sample and clarification on how this would be done
- CF – consent boxes should be bigger
- Clarification that any recommendations resulting from the study would be met service wide in Coventry and not unduly raise expectations for the patient

The Committee agreed that this study was SSA exempt.

### **Decision :**

**The Committee gave a provisional favourable opinion subject to sight of :**

- **Approach letter**
- **Revised PIS**

Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chair.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 02 November 2007.

### **Ethical review of research sites**

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. However, all researchers and local research collaborators who intend to participate in this study at NHS sites should seek approval from the R&D office for the relevant care organisation.

### **Membership of the Committee**

The members of the Committee who were present at the meeting are listed on the attached sheet.

### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

07/H1211/78

Please quote this number on all correspondence

Yours sincerely

  
**Mr Paul Hamilton**  
**Chair**

**Enclosures:** *List of names and professions of members who were present at the meeting and those who submitted written comments.*

**Copy to:** *Professor Ian Marshall*  
*R&D Department for NHS care organisation at lead site*



Warwickshire Local Research Ethics Committee

Attendance at Committee meeting on 27 June 2007

Committee Members:

Name	Profession	Present	Notes
Dr Jane V Appleton	Nurse	No	
Dr J W Bland	GP Principal	Yes	
Dr Helen Brittain	Clinical Psychologist	Yes	
Mrs Barbara Canning	Lay Member	Yes	
Mr Matthew Dunn	Consultant, Accident and Emergency	Yes	
Dr. Mike Graveney	Consultant in Public Health Medicine	Yes	
Mr Paul Hamilton	Local Government Officer	Yes	
Ms Evette Hutchinson	NHS Lay Member/Mature Student	Yes	
Mrs. Sue Jayram	Nurse	Yes	
Rev'd Dorrie Johnson	Reverend/Nurse	Yes	
Cllr Bill Lowe	Cllr - Lay Member	Yes	
Mr Anthony Parsons	Consultant Obst. & Gynaecologist	No	
Dr Ashok Roy	Consultant Psychiatrist	Yes	
Mr Harvinder Singh	Medical Sciences Officer	Yes	
Dr Mike Walzman	Consultant Physician	No	

### Appendix 3: Coventry University Ethics Committee Letter of Approval



# Memorandum

Coventry University

Faculty of Health & Life Sciences

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**To** Bhavisha Dave

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**From**  
Rhoda Morgan

**Cc**

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<b>Extension email</b>	<b>Delivery Point</b>
5985      r.morgan@coventry.ac.uk	RCG17

---

**Our Reference**  
PG50/07

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**Date**  
04 June 2007

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Dear Bhavisha,

**Coventry University Ethics Committee**

Thank you for submitting your application to Coventry University Ethics Committee.

I am pleased to inform you that your application has been approved. Please find a signed copy of Form 1 and a Peer review form for you reference.

Best wishes for your research project.

Regards,



Rhoda Morgan  
Secretary  
Coventry University Ethics Committee  
Tel: 024 7679 5985

# COVENTRY UNIVERSITY ETHICS COMMITTEE (FORM 4)

## PEER REVIEW FORM

<b>Reference No: PG50/07</b> (Bhavisha Dave)
<b>2. Title of study.</b> South Asian Women and eating difficulties: underlying reasons, needs and service implications
<b>3. Scientific background, design, method and conduct of the study.</b>  Reasonable scientific background, but without seeing the interview schedule and 'demographic questionnaire' it is hard to assess whether the study is justified adequately.  Inappropriate use of the terms 'experimental' and 'control' group in the protocol. They are comparison groups.  What demographic data are being collected? Why? What questions will be within the interview schedule? The questions on the participant information sheet (PIS) look innocuous, but given how sensitive the topic is, the reviewer would need to know what questions are to be asked. Might participants be asked to disclose, for example, experiences of sexual abuse/domestic violence? Not mentioned in the PIS but potentially relevant.  The statement in section 12 about secure storage of data needs to be more specific: what arrangements for secure storage of both hard copy and electronic data formats?  The protocol states that participants will be debriefed (sic) <i>before</i> data are collected, but not after. What procedures are in place for debriefing post interview?
<b>4. Recruitment of participants.</b> It is proposed that women using the eating disorders service be selected at random from the service's database. It is not clear who will do this. If it is the clinical supervisor and he will be involved in viewing/analysing the data, then it likely that participants will be identifiable. This contradicts the statement in the last paragraph of the first page of the PIS.
<b>5. Care of researcher and participants and protection of research participants' confidentiality.</b> I have concerns about participants' confidentiality as above. Who will have access to the database and will service know who has participated? Any statements made to participants about anonymity need to match what will actually happen in the study.
<b>6. Informed consent.</b> The consent form used complies with COREC requirements, but should it not be on NHS Trust headed paper?

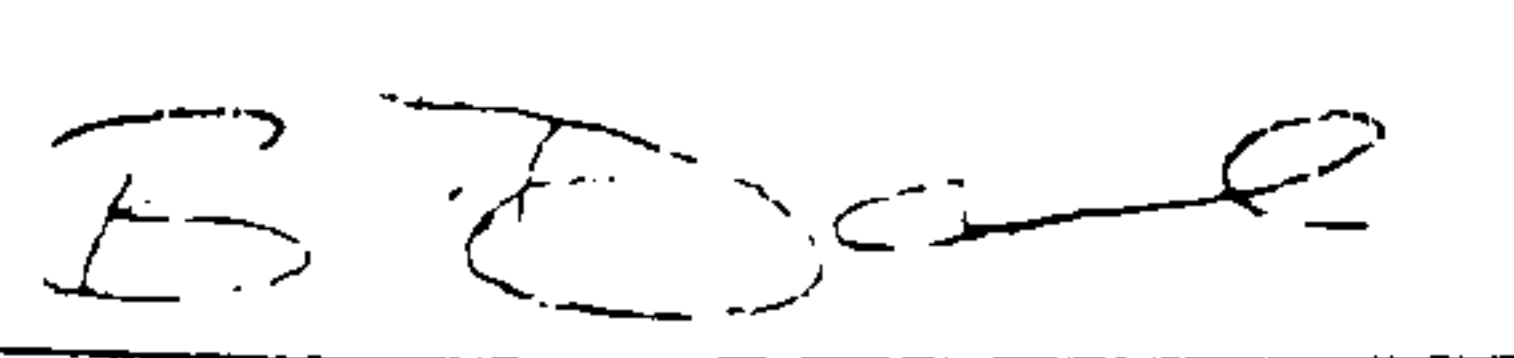
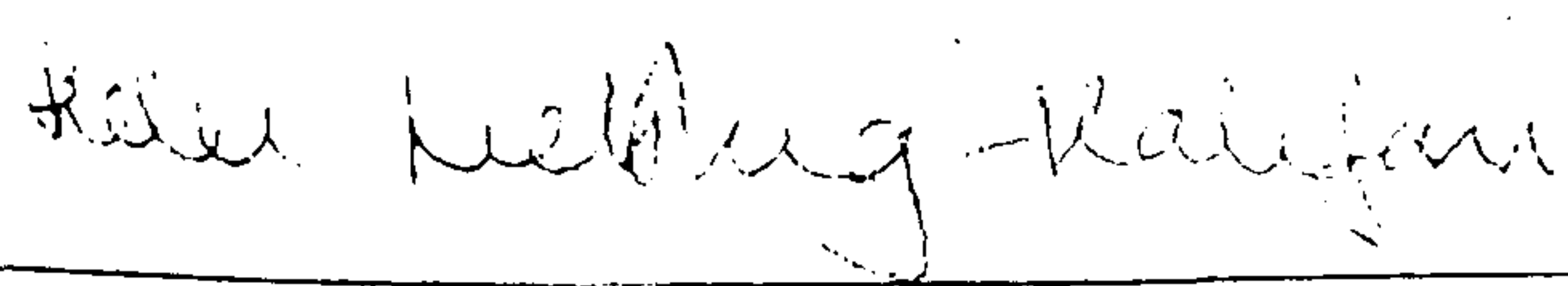
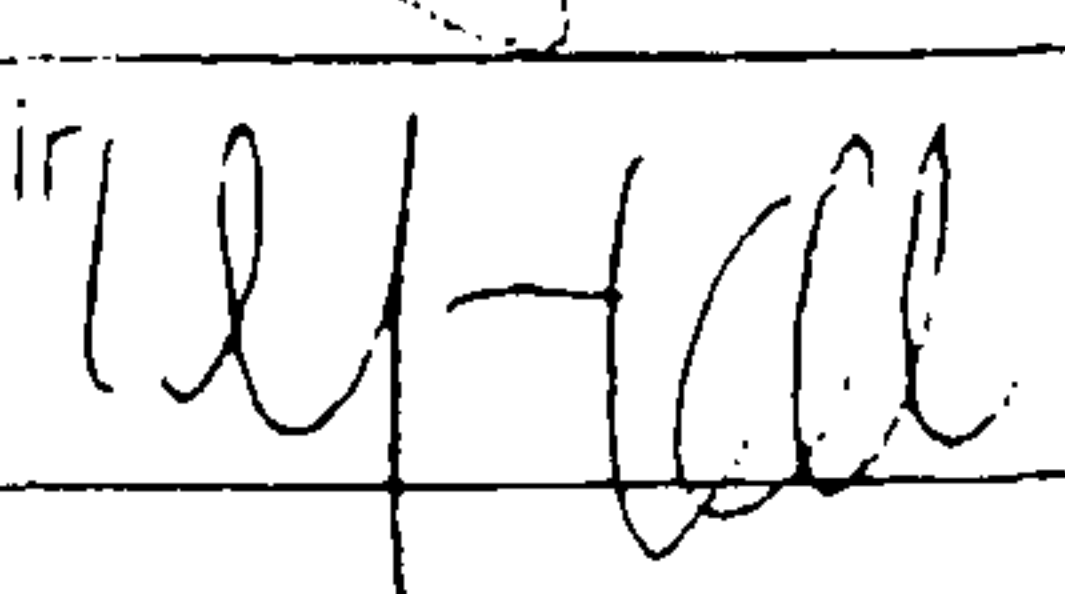


<b>7. Community considerations:</b> The study has the potential to further understanding and benefit patients/service users, if conducted appropriately	
<b>8. Information sheet.</b> This needs to conform more closely to the headings in the COREC template.	
<b>9. Consent form.</b> Should this not be on NHS Trust headed paper?	
<b>10. Comments on the ethical aspects of the proposal.</b>  On the face of it this is a simple and innocuous project, but it deals with potentially sensitive personal experiences. The researcher needs to demonstrate sensitive awareness of these issues by providing more detail about the conduct of the study, to comply with current ethical requirements.	
<b>11.Recommendation</b> Approval with no amendments. <input type="checkbox"/> Approval subject to specified conditions. <input checked="" type="checkbox"/> I do not feel that this application is ready to go forward to NHS ethical approval yet. Need to: <input type="checkbox"/> Include the questionnaires and interview schedule. <input type="checkbox"/> Need to clarify selection of participants from database. <input type="checkbox"/> Need to reconcile statements about confidentiality in PIS with reality of who will see participants' names and other data. <input type="checkbox"/> Need to amend PIS to match standard format. <input type="checkbox"/> Need to clarify procedures to comply with data protection act. Reject. <input type="checkbox"/>	
<b>Completed by:</b> Carol Percy	<b>Date</b> Wednesday, 18 April 2007

*Please return this form electronically to [r.morgan@coventry.ac.uk](mailto:r.morgan@coventry.ac.uk)  
 DO NOT CONTACT THE APPLICANT DIRECTLY..*

# COVENTRY UNIVERSITY ETHICS COMMITTEE (Form 1)

## POSTGRADUATE STUDENT & STAFF APPLICATION FOR ETHICAL APPROVAL

<b>Name</b> Bhavisha Dave		<b>E-mail</b> daveb@coventry.ac.uk
<b>Designation / Subject &amp; Faculty:</b> Trainee Clinical Psychologist, Clinical Psychology Doctorate		
<b>Title of Study:</b> South Asian women and eating difficulties: underlying reasons, needs and service implications		
<b>1. Summary of proposal</b> This research aims to identify themes in relation to the development of eating difficulties in South Asian women and to assess if these themes are different to their Caucasian counterparts. The research also hopes to evaluate the needs for people with eating disorders and assess whether or not a specific service is meeting the needs of such service users.		
<b>2. Sample of participants</b> 8-10 South Asian women and Caucasian women with eating difficulties.		
<b>3. Site/s location</b> Coventry Eating Disorders Service		
<i>Tick / Cross. *Where answered 'NO', please give reasons on separate page.</i>		
<b>4. Scientific background, design, method and conduct of the study.</b>		<b>Yes</b>
a) Have you given a justification for the research?		√
b) Have you commented on the appropriateness of the design, the perceived benefits, risks and inconveniences to participants?		√
<b>5. Recruitment of participants.</b>		<b>Yes</b>
Have you provided a comprehensive account of the characteristics of the population including the process for obtaining access as well as the inclusion and exclusion criteria?		√
<b>6. Care and protection of research participants and researcher.</b>		<b>Yes</b>
Have you given an account of any interventions, situations and risks which have the potential to cause harm to the participants and researchers?		√
<b>7. Access, storage, security and protection of participants' confidentiality.</b>		<b>Yes</b>
Have you identified who will have access to the data and what measures have been taken to ensure confidentiality and compliance with the Data Protection Act?		√
<b>3. Informed Consent.</b>		<b>Yes</b>
Have you given a full description of the process for requesting and obtaining informed consent?		√
<b>9. Community considerations.</b>		<b>Yes</b>
Have you considered how this study will benefit the participants or the community from which they have been drawn?		√
<b>10. Participant information Sheet and consent form.</b>		<b>Yes</b>
Are these attached?		√
<b>11. Source of External Funding if any</b>		
Signature of student / staff 	Address Clinical Psychology, Room JSG24, James Starley Building, Priory Street, Coventry CV1 5FB	Date 10/04/07
Signature of Supervisor 	Print Name Internal Address Helen Lickling-Katlyani AS ASUE - J	Date 10/04/07
Signature of Chair 	<input type="checkbox"/> Approved. <input checked="" type="checkbox"/> Approved with the conditions below:	Date 24/4/07



Conditions / Comments:

PLEASE REFER TO PEER REVIEW FOR COMMENTS

Please complete in full and return to: **Research Manager, CU Ethics Committee, Richard Crossman RCG17, Coventry University.**

This form should be accompanied by the full research study proposal, or the COREC form if applicable. Further help & information can be found on W / HLS / Student / Ethics or call Rhoda Morgan on 024 7679 5945, or e-mail [r.morgan@coventry.ac.uk](mailto:r.morgan@coventry.ac.uk).

## West Midlands South RM&G

C/o Research & Development Office  
University Office Suite  
First Floor Rotunda  
University Hospitals of Coventry  
& Warwickshire NHS Trust  
University Hospital  
Clifford Bridge Road  
Coventry CV2 2DX

Miss Bhavisha Dave  
Clinical Psychology  
Room JSG24  
James Starley Building  
Priory Street  
Coventry  
CV1 5FB

07 December 2007

R&D Ref: PAR160807  
REC Ref: 07/H1211/78

Dear Bhavisha

I am pleased to confirm that **Coventry & Warwickshire Partnership Trust** has reviewed your research study entitled 'South Asian Women and eating difficulties: underlying reasons, needs and service implications' and give approval for you to conduct this research within the Trust on the condition that the Trust suffers no costs as a result of this study being undertaken, other than the minimal travel expenses (charged at public transport rate) of participants, as agreed with Peter Watson, Head of Psychological Services. Your research has been entered into the Trust's Research database (if applicable this will be entered onto the National Research Register).

**Please reply to this letter confirming the expected start date and duration of the study.** As part of the Research Governance Framework it is important that the Trust is notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. We may also request brief updates of your progress from time to time, dependent on duration of the study. Similarly, if at anytime details relating to the research project or researcher change, the R&D department must be informed.

If you have any further questions regarding this or other research you may wish to undertake in the Trust please feel free to contact me again. The Trust wishes you success with your research.

Yours sincerely

Clare O'Neill  
R&D Project Manager



Appendix 5  
Participant Approach letter

Dear .....

**Research Study: South Asian Women and Eating Difficulties; underlying reasons, needs and service implications.**

I am writing to invite you to take part in a research study which I am carrying out as part of my clinical training. My name is Bhavisha Dave and I am a Trainee Clinical Psychologist studying for a Doctorate in Clinical Psychology at the universities of Coventry and Warwick. I am interested in the different factors which contribute to eating difficulties in women of specific ethnic groups. I am also interested in your feedback on the input which you have received from Coventry Eating Disorders Service.

The following people are involved in this research:

Bhavisha Dave  
Trainee Clinical Psychologist at the Universities of Coventry and Warwick  
Telephone number: 02476 521130

Ken Goss  
Consultant Clinical Psychologist and Head of Coventry Eating Disorders Service  
Telephone number: 02476 521130

Dr Helen Liebling-Kalifani  
Research Tutor at Coventry University  
Telephone number: 024 7688 7806

Please find enclosed a participant information sheet explaining the nature of the study in more detail and a consent form for participation in the research study. Please ensure that you read both the participant information sheet and consent form fully before deciding whether or not you would like to participate.

If you decide to take part in the study then please put your initials in the boxes on the consent form and then sign and return the form in the stamp-addressed envelope provided. If you have any questions regarding any aspects of the research study please feel free to contact me on the telephone number above.

I would like to take this opportunity to thank you for reading this letter.

Yours sincerely

Bhavisha Dave  
Trainee Clinical Psychologist



### Participant Information Sheet

1) Study title:

South Asian Women and Eating Difficulties; underlying reasons, needs and service implications.

2) What is the purpose of this study?

This research hopes to explore what factors contribute to eating difficulties in specific female ethnic groups and if these factors are different to other ethnicities. The research also hopes to assess whether or not services are meeting the needs of women with eating difficulties and if not then how services could better cater for the needs.

3) Why have I been chosen?

You have been chosen to take part in the study as a service user of the Coventry Eating Disorders Service. I would like to gain a better understanding of your experiences and hopefully this research will help benefit women at Coventry Eating disorders Service as findings will help services to meet the needs of services users.

4) Do I have to take part?

You do not have to take part in the research and if you do wish to take part and then withdraw from the study at any point if you change your mind you are free to do so, without it affecting the treatment you receive.

5) What will happen to me if I take part?

You will be asked to take part in an interview. The interview will take approximately 1 hour within which you will be asked questions relating to your experiences of eating difficulties and of attending Coventry Eating Disorders Service.

6) What are the possible disadvantages and risks of taking part?

You may feel inconvenienced by taking part in the interviews and thus the research team will be sensitive to this and measures will be taken to minimise the inconvenience, for example by taking breaks as required.

Discussion of eating difficulties may cause some emotional distress; in the event of this happening you will be offered the opportunity to stop the interview if you wish to.

7) What are the possible benefits of taking part?

It is possible that involvement in the research may enable you to think about your eating difficulties in further depth. You will also be given an opportunity to discuss your experiences regarding the access and treatment within the service which may be a positive experience for you.



**8) What if something goes wrong?**

If you do take part in the research there is a chance that you may talk about something which distresses you. You do not need to continue to take part if you do not wish to. There will also be further support available from Coventry Eating Disorders Service following the research if you feel this is required. Contact details for external support agencies will also be provided on request.

**9) Will my taking part in this study be kept confidential?**

This study will comply with the Data Protection Act 1998 and your participation will be kept confidential. However if you tell me something about yourself or that of another which results in either being in any danger I will be obliged to inform a colleague outside the research. Any data which may identify you will be locked in a secure filing cabinet and no identifiable information will be included in any report or publication relating to this study. Your GP will have no involvement in this study but will be informed of your participation with your permission.

**10) What will happen to the results of the research study?**

The anonymised results of the research will be used for submission of a doctoral thesis and will be submitted for selected journal publication.

**11) Who is organising and funding the research?**

The research will be organised by myself in conjunction with Coventry University. Travel expenses will be funded by Coventry & Warwickshire Partnership Trusts.

**12) Who has reviewed the study?**

The study is reviewed by peer reviewer from Coventry University, COREC & LREC ethics committees.

**13) Contact for further information**

If you would like to take part in this research, please get in touch with me at the address/number below:

Bhavisha Dave  
Trainee Clinical Psychologist

Coventry Eating Disorders Service  
James Brindley House  
Canal Basin,  
St Nicholas Street  
Coventry CV1 4LY  
Tel: 024 76521130

**If you would like to take part in this research please send the consent form to Bhavisha Dave at the above address in the envelope provided.**

**Participant Consent Form**

Title of research: South Asian Women and Eating Difficulties; underlying reasons, needs and service implications.

Chief Investigator: Bhavisha Dave

Please initial  
box

1. I confirm that I have read and understood the information sheet dated..... (version....) for the above study. I have had the opportunity to ask questions accordingly and these have been answered satisfactorily.

☐

2. I know that I can withdraw my participation at any point during the research without it affecting my treatment/care.

☐

3. I understand that the information I will provide will be anonymous in any report or publication.

☐

4. I give permission for the research team in the above study to have access to my records.

☐

5. I understand that the interviews will be tape-recorded and the tape recordings will be destroyed after completion of the doctoral course.

☐



Appendix 7

6. I agree to my GP being informed of my participation in the study. ☐

7. I agree to take part in the above study. ☐

Name of participant:	Signed:	Date:
.....	.....	.....

Name of Researcher:	Signed:	Date:
.....	.....	.....

## Appendix 8

**Participant Interview Questions**

- I: Thank you for taking part in the research. What's your age?
- I: What is your ethnic origin?
- I: When did you first have contact with Coventry Eating Disorders Service?
- I: Have you had any contact with any other Psychological Services before?
- I: Did you know anybody else you had contact with Coventry Eating Disorders Service prior to your first contact?
- I: In your opinion what led you to have this contact with the Service?
- I: Why did you attend Coventry Eating Disorders Service?
- I: At what age would you say that the eating difficulties started?
- I: Is there anyone who you can talk to not including from CEDS about your eating difficulties?
- I: Did you have any strategies to help you cope with your eating difficulties before you attended Coventry Eating Disorders Services?
- I: In your opinion how did you find the process of accessing CEDS?
- I: What were your expectations of CEDS when you had your first contact with the service?
- I: Do you think that your expectations were met by CEDS?
- I: What type of input have you received or are you receiving from Coventry Eating Disorders Service?
- I: Do you think CEDS should offer any other input for example different types of groups?
- I: How could Coventry Eating Disorders Service be improved?
- I: What are the things you most like about Coventry Eating Disorders Service?
- I: Do you have any further comments?



## Appendix 9

**Excerpts from the Reflective Diary**First Interview Diary Notes

The interview was really tough I'm not sure if it was because of the fact that it was the first interview of the research or the content of the interview. I was really exhausted. The participant was able to describe her experiences in detail and I was aware that I was trying my best to let her guide the interview responses and so was mindful of my own verbal and non-verbal reactions. I had a sense that the participant assumed that I knew her culture and would understand some of her experiences and so trying to stay neutral while she was making references to 'our culture' was difficult. I talked to my clinical supervisor about the interview pretty much straight after because I knew that I needed time to reflect on the process of carrying out the interview but also how I was left feeling. One of the advantages of experiencing this difficulty at the onset was that it prepared me for future interviews.

Sixth Interview Diary Notes

It was the start of interviewing Caucasian participants and to be honest a part of me was relieved because I could now be seen as a researcher and not as an Indian researcher. The latter was what I felt the South Asian Participants were seeing me as. The participant appeared quite comfortable about talking to me about her experiences and the answers were given quite quickly. It seemed that she had reflected on the impact of experiences on the eating disorders and so doing the interview was not difficult. This may have been due to having talked about her experiences for some time while engaging in therapy. The participant seemed quite positive about the future and appeared quite optimistic about overcoming her difficulties with her eating disorder.



**Excerpts from the Memo notes**Adverse Childhood Experiences

Both South Asian and Caucasian groups talked of experiencing traumatic events in childhood. The most widely discussed trauma was abuse. They described the various ways this had impacted on them. Neither groups particularly talked about telling other people about the abuse and of those that did, they did not feel that it was helpful. In the interviews the disclosure of the abuse tended to be when I asked them if there were any experiences that they thought may have triggered or contributed to their eating disorder. It seems that the abuse played an important part in how they felt about themselves but does it show a causal link? There does not seem to be enough evidence to suggest this from the interviews.

Influence of Culture

The South Asian participants reported that they could not talk to family members about their eating disorders. The Caucasian participants seemed not to have many difficulties with disclosing their eating disorder. Why the difference? South Asians seem resigned to the fact that they have to cope with their eating disorder alone. What is holding them back? They talk about not wanting their families to know but what is deterring them? Most of the South Asian participants discussed the role of their culture and the lack of understanding and awareness of mental health difficulties. Culture seems to play an important part in the lives of the South Asian participants so much so that they risk not talking about their difficulties to meet the cultural expectations.

Accessing Treatment

There was a clear divide between participant groups. The South Asian group tended to talk about accessing support because their eating disorder had become unmanageable to the extent that they could not cope with it anymore. There seems to be a split, on one hand the South Asian participants wanted support for their eating disorders but are deterred by accessing treatments to help them due to their culture. The Caucasian group on the other hand reported that they accessed help when they felt ready and feel more confident about talking about their difficulties.



## Appendix 11

Examples of open Coding

Access support during difficulty  
 Acute stages  
 Afraid of parents finding out  
 After marriage- comments  
 Age differences from group members  
 Aged eleven to sixteen put on weight  
 Ages sixteen seventeen had healthy eating regime  
 Alert GPs re: eating disorder symptoms  
 Alone  
 Alone after leaving service  
 Angry with others for expecting from her  
 Argument in family while growing up  
 Arguments in household  
 Arguments in the house whilst growing up  
 Asian community can be hurtful  
 Asian community label  
 Asian cultural rules  
 Asian culture- blamed spiritual sources for difficulties  
 Asian culture- difficult to explain to others  
 Asian culture- divorce  
 Asian culture- do not understand  
 Asian culture- extended family  
 Asian culture- for marriages  
 Asian culture- had to stay in difficult marriage  
 Asian culture- lack understanding  
 Asian culture- loves culture  
 Asian culture- not allowed to attend Psychological services  
 Asian culture- not attending out of fear of label  
 Asian culture- people do not let go of past  
 Asian culture- people know each other  
 Asian Culture- pressure to be a certain way  
 Asian culture- unit family identity not individual identity  
 Asian culture - dismissive of Ed  
 Asian culture - stigma  
 Asian culture expectations  
 Asian culture generational differences  
 Asian culture pretend things have not happened  
 Asian culture restrictions  
 Asian culture silence  
 Asian people- unsure how many have had eating disorder  
 Asian Saying- negative comments  
 Asians did not want to help  
 Assumption that people are more aware of difficulties  
 Assumption that people cope more now  
 Assumption that people have more support now  
 Assumption that people speak up more now  
 Ate too much on birthday  
 Attempted to do what she wanted alone  
 Attend classes by CEDS  
 Aunt will not admit ED but cousin will  
 Avoids talking about it now  
 Aware of what you are eating  
 Became more active  
 Became pregnant  
 Became studious  
 Became withdrawn  
 Being compared to others  
 Being told she is fat  
 Believed she deserved it



## Appendix 11

Believed she was unlovable  
 Bines at parents house  
 Bingeing  
 Bingeing-purging  
 Blamed for mother becoming ill  
 Blamed self  
 Blocked everything to survive  
 Body shape  
 Brain washed into sleeping with partner  
 Brother became alcoholic  
 Brother had talked to her about family  
 Brothers restricted from seeing her  
 Brought shame onto family  
 Bullied by cousins  
 Can cope  
 Can love others  
 Can mask difficulties  
 Can talk to her sons  
 Cannot accept others loving her  
 Cannot change past or get out of it  
 Cannot function if others do not need her  
 Cannot get rid of past  
 Cannot love self- does not know how to  
 Cannot talk about difficulties in group  
 CEDS- another Asian would understand culture  
 CEDS- Asian support  
 CEDS- benefited from help  
 CEDS- body image group  
 CEDS- body image was good  
 CEDS- can talk to people  
 CEDS- comfortable  
 CEDS- could talk to them  
 CEDS- did body image group  
 CEDS- did help  
 CEDS- did not realise the intensity of the contact  
 CEDS- did not understand cultural differences  
 CEDS- did not understand Indian culture  
 CEDS- difficult for them to understand culture  
 CEDS- difficult to follow advice given due to cultural differences  
 CEDS- do not force you to do anything  
 CEDS- easy access  
 CEDS- eating plan is important  
 CEDS- everyone was welcoming  
 CEDS- expectations were met  
 CEDS- expected everything would be okay  
 CEDS- expected they would have all the answers  
 CEDS- expected to be trained to eat normally  
 CEDS- expecting big centre  
 CEDS- fear of not being recognised as ED due to normal weight  
 CEDS- found difficult as not cater for individual needs  
 CEDS- give people time to think  
 CEDS- group members all youngsters  
 CEDS- group members young  
 CEDS- had assessment  
 CEDS- had assessment and Psychoed group  
 CEDS- had been through eating disorder longer than others in group  
 CEDS- had Psychoed and maintenance  
 CEDS- happy for someone to listen  
 CEDS- having appts  
 CEDS- interview was emotional and upsetting  
 CEDS- likes most: confidentiality



Appendix 11

CEDS- make people more aware of service  
 CEDS- more information needed about service  
 CEDS- needed more time in recovery input  
 CEDS- needs more awareness of service available  
 CEDS- needs to be more accessible  
 CEDS- nice people  
 CEDS- no awareness  
 CEDS- no contact  
 CEDS- only eldest group member  
 CEDS- people were helpful  
 CEDS- prefers access when required rather than group work  
 CEDS- prepared to listen and understand  
 CEDS- process okay  
 CEDS- questions how much they understand  
 CEDS- realistic boundaries of input  
 CEDS- recocevry programme helpful  
 CEDS- retraumatised from speaking about difficulties  
 CEDS- right approach  
 CEDS- scared to come to  
 CEDS- she was not interested in group or art work  
 CEDS- suggestion of being at the main hospital  
 CEDS- suggestion patients may feel more comfortable at the main hospital  
 CEDS- supportive  
 CEDS- there if you need help  
 CEDS- they do not judge you  
 CEDS- they understand  
 CEDS- thought there would be lots of 'thinner' people questionnign why she was attending  
 CEDS- unaware of what is offered  
 CEDS- unsure about other support that should be offered  
 CEDS- unsure what to expect  
 CEDS- waiting time between GP and CEDS input was long  
 CEDS- wanted individual intervention from them but it was not offered  
 CEDS- wants individual support  
 CEDS- wants long term support  
 CEDS- wants them to offer support for traumas  
 CEDs- wary to attend service  
 CEDS- was happy to get help  
 CEDS- was there in her forties  
 CEDS- would have been helpful if they catered for culture differences  
 CEDS- would have been helpful if they understood Asian culture  
 CEDS- would have benefited if family group was more informative  
 CEDS- would have wanted more family input  
 CEDS-Access very good  
 CEDS-Had to withdraw from service due to work committments  
 CEDS - accessed when having a low episode  
 CEDS - cried after first appt  
 CEDS - quick to access them  
 CEDS explained procedure  
 CEDS felt she knew what was being taught  
 CEDS group work  
 CEDS groups aimed at youngsters  
 CEDS helpful in realising she was not to blame  
 CEDS offer background information about eating disorder  
 CEDS questionnaires  
 CEDS\_ was not prepared for the hard work  
 Certain situations triggers feelings from past  
 Channelled love to others  
 Child does not know her  
 Children are grown up



## Appendix 11

Choices given by CEDS  
 Cleanse body  
 Clothes baggy  
 Comfort ate  
 Comfort ate between aged eleven and sixteen  
 Coming to CEDS for appointment - realisation of how much ED affected her  
 Compared her to relative  
 Compared to others  
 Compared to siblings  
 Compared to slim cousins  
 Comparison of looks to others  
 Confidentiality  
 Considered various ways of getting help- even private US treatment  
 Constantly trying to please others  
 Contact was easy  
 Continued until aged eighteen  
 Controlling food  
 Coped alone  
 Coped alone with ED until she went to CEDS  
 Copes alone  
 Copes by being there for others  
 Coping strategy  
 Coping strategy - vomit or restrict  
 Could not control eating  
 Could not cope anymore  
 Could not deal with ED anymore  
 Could not go to GP initially  
 Could not live with ED anymore  
 Could not put parents through finding out about ED  
 Could not speak openly to the doctor  
 Could not talk to family about sister's death  
 Cousins expect more from her  
 Cultural changes in area of residence  
 Cultural differences to other group members  
 Cut off from family  
 Cut self off from dad's side of family  
 Daughter is motivation to avoid ED behaviour  
 Deals/copes alone  
 Death of sister- trigger to ED  
 Decided to restrict food  
 Denied to self that she had ED  
 Deserved what happened to her  
 Did not deserve to be loved  
 Did not feel like she belonged in family  
 Did not know how to deal with father's violence  
 Did not know why she was punishing self  
 Did not like moving  
 Did not say bye to brother who died  
 Did not used to be studious  
 Did not want child to suffer  
 Did not want community to label her  
 Did not want ED on her records  
 Did not want to attend when appt date came closer  
 Did not want to come to terms with ED  
 Did not want to go to doctor  
 Did not want to let parents down  
 Difficult divorce  
 difficult going to GP  
 Difficult to explain to others  
 Difficulty with eating disorder behaviour



## Appendix 11

discharged from hospital sooner than scheduled  
Dislikes going out for meals  
Disowned by father  
Distanced self from cousins  
Do people overcome eating disorders  
Doctor wanted a Psychological referral  
Does not blame self now  
Does not get on well with father  
Does not know who she is or what she needs  
Does not know why her mother treats her this way  
Does not talk about other life events with others  
Does not talk to relatives about ED  
Does not want daughter to suffer from it  
does not want parents to compensate for ED  
Does not want parents to monitor what she eats  
Does not want sons to feel like they are to blame  
Does not want to burden others  
Doubts other's motives if they are nice  
Duty as a daughter  
Eating disorder  
Eating disorder as a coping mechanism  
Eating disorder not as severe as when younger  
Eating disorder started at age eleven  
Eating disorder still present  
Eats on certain days at parents house  
ED- hard to deal with  
ED became better when she talk about it  
ED is a constant battle  
ED is control  
ED is isolating  
ED needed to be addressed  
ED not constant  
ED onset in childhood  
ED was harder when younger  
Effort to eat food  
Emotional upbringing  
Exercise to lose weight  
Explains individuality of disorder  
Family blaming her for her difficulties  
Family concerned about ED  
Family could not see that her difficuties were consequences of her experiences  
Family could not talk to her about her difficulties  
Family did not understand  
Family do not understand  
Family event- would calorie chack  
Family intervened- talked of shame she would bring to family  
Family knew she was unwell at onset  
Family made appt for her to see GP  
Family make her feel guilty  
Family not acknowledged she was underweight  
Family responsibility  
Family still try to have an opinion on her life  
Family told her to marry partner  
Family triggers eating disorder  
Family unaware of CEDS attendance  
Family unaware of ED  
Family was belittled  
Family well known in community  
Family worried about society  
Family would confront her why she avoided them

Appendix 11

Father's violence was damaging to children  
 Father controlled what she could say  
 Father dominant  
 Father ridiculed and mocked her  
 Father stopped her from going to the house  
 Father supported her sister  
 Father used to drink alcohol  
 Father used to taunt her  
 Father violent  
 Father violent to other family members  
 Father wanted to force feed her  
 Father would make excuses for her difficulties  
 Fear of being labelled  
 Fear of group members breaching confidentiality  
 Fear of how much to disclose  
 Fear of past arising  
 Fear over child's safety  
 Feared GP would tell parents  
 Feel envious of cousin  
 Feels friend dismisses ED  
 Fell in love with partner  
 Felt guilty  
 Felt helpless  
 Felt out of place as the only Asian  
 Felt pressure to continue losing weight  
 Felt she was being teased about weight  
 Felt there had to be something wrong with her  
 Felt unloved  
 Felt unwanted  
 Felt useless  
 Focused on others to cope  
 Focusing on daughter  
 Focussed on body image  
 Focussed on child  
 Food filled a void  
 Food was comfort  
 Food was comfort when bad things happened  
 Food was entertainment  
 Forced to cope alone  
 Forced to cut ties from family  
 Forced to have sex  
 Forced to stay in marriage  
 Forced to stay quiet  
 Forced to watch abuse  
 Friend at the gym encouraged her to seek help and go to GP  
 Friend does not understand  
 Friend encouraged her to come  
 Friend explained calories  
 Friend helped her  
 Friends and few members of family know about ED  
 Friends changed- out of wrong crowd  
 Friends not talking to her - trigger to access help  
 Friends noticed ED behaviour  
 Friends stopped talking to her because of ED  
 Friends threatened to tell parents  
 Friends watch what she eats  
 Generation changes in triggers to eating disorders  
 Gets on with life  
 Girl at the gym suffered from AN  
 Given promises by partner  
 Good outcome from marriage



## Appendix 11

Got approval when lost weight  
 Got praise  
 Got to a point where she did not care who found out  
 Got wilpower to seek help  
 Gp and friends encouraged referral  
 GP and hospital Consultant led to contact  
 Gp did not understand  
 Gp does not take her seriously  
 GP encouraged her to come  
 GP encouraged her to go to CEDS  
 GP got her into contact with CEDS  
 GP had impression of confident person  
 GP has no time  
 GP helped her  
 GP mentioned CEDS  
 GP monitoring can avoid  
 GP not respect confidentiality due to links with family  
 GP put her on medication  
 GP questioned why she thought she had ED  
 GP recommended CEDS  
 GP response helpful  
 GP sent referral  
 GP unable to identify real reason why need help  
 GP was caring  
 GP was considerate  
 Gp was helpful  
 GP well known to whole family  
 Grandfather was an alcoholic  
 Grandmother was nasty  
 Grandparents passed away  
 Grandparents put her down  
 Guilt if overeaten  
 Had a self-help book for ED  
 Had been dealing with ED for years  
 Had bulimia  
 Had determination  
 Had done some reading about ED to help her prior to CEDS contact  
 Had eating disorder when younger  
 Had focus  
 Had labelled self  
 Had problems  
 Had some own ideas  
 Had to be careful with who judges  
 Had to cope  
 Had to explain her situation to her children  
 Had to live with being bullied  
 Had to put child into care  
 Had to seek private help  
 Had to stay with sister rather than friends  
 happy now  
 Hard telling GP about ED  
 Harsh words by family  
 Has control with ED  
 Has friends she can talk to  
 Has three sons one is in care  
 Hated her life  
 Hated self  
 Hated slf  
 Hates ED  
 Having own boundaries  
 Her child was hurt from the violence

## Appendix 11

Her children are her priority now  
Her desperation led her to seek help  
Her difficulties were dismissed  
Her mum will not say she loves her  
Her sons look out for her  
Her sons notice when she is losing weight  
Hide true illness from doctor  
Holding back from ED behaviour  
Hurtful comments from family  
Hurtful relatives  
Husband- able to talk to him  
Husband- accepting who she is  
Husband- supportive  
Husband- would be lost without him  
Husband aware of ED  
Husband did not like or love her  
husband does not judge her  
Husband guides her to focus on daughter  
Husband turned sons against her  
If parents found out they might think she has disappointed them  
In search for answers  
Independence  
Indian GP  
Initially could not tell anyone about ED  
Intimidated by dad's side of the family  
Isolated self  
It hurts other to know she has ED  
Keeping family identity is difficult  
Keeps barrier  
Knew the reasons for eating disorders  
Knows she will binge if going out  
Labelled by people  
Language barrier  
Late teens ED behaviour  
Left alone after input from service  
Lied to by partner  
Lies to family about eating  
Liked helping others  
Limited with what she can talk to relatives about  
Linked not being interested in groups and art due to culture  
Lived with ED for so long  
Lived with parents and grandparents  
Looked after others  
Looked after rest of family  
Lost weight  
Made to feel like second best by father  
Made to feel she deserved physical problems  
Made to feel she should be super human  
Made to feel she was to blame  
Made to go to grandparents house against free will  
Makes sure she is there for her sons  
Marital violence increasing  
Marriage difficulties trigger eating difficulties  
May have further self harmed if it went on for another year  
Maybe able to tell aunt about ED  
Media images impact ED  
Media influence  
minimal calories  
mirror check in the morning  
Monitoring  
More open to talk about ED now



## Appendix 11

Mother's sister was hurtful  
Mother acknowledges parts of history  
Mother and brother assume she has recovered  
Mother and brother initially supportive but now assume ED is gone  
Mother defends father  
Mother did not have any escape  
Mother forced to stay in marriage  
Mother forcing her to eat  
Mother had little say in household  
Mother had no family she could seek help from  
Mother made comment about body  
Mother needs sons to take care of her  
Mother put up with violence  
Mother says not to focus on cousins  
Mother stayed quiet  
Mother supported brothers  
Mother told brother  
Mother told her to be individual and not compare  
Mother told her to let others deal with divorce  
Mother tries to get her not to rely on CEDS  
Mother tries to offer focus but does not understand  
Mother used to mock  
Mother was supportive  
Mother will not show her affection  
Mother would be in denial about ED  
Mother would minimise ED  
Mother would not understand  
Mother would notice if she got too thin  
Moved house  
Moving house upset her  
mum's sister obsessed with food  
Mum and brother are now aware  
Mum wants her to lose weight  
Need to feel needed  
needed help to gain weight  
Needed to talk to someone about it  
Nervous about attending  
Never did any sports at school  
No avenue to seek help due to restrictions  
No awareness of CEDS  
No control  
No coping strategies to help her  
no friends due to moving house  
No help from others  
No knowledge of others contact with CEDS  
No one to talk to  
No one understands  
No other route apart from GP to CEDS helpful  
No other route apart from parents finding out  
No praise  
No prior Psychology contact  
No real strategy had vicious cycle  
No siblings- only child  
No support  
Not comfortable talking thorough problems in the group  
Not going to please cousins anymore  
Not losing weight  
Noticed eating disorder behaviour increasing  
Now avoids being hurt  
Now stronger  
Now wants to be happy within self

## Appendix 11

Now wants to focus on self  
Nurtured by food  
Only two friends know  
Onset - called names  
Onset eighteen-nineteen  
Onset of eating disorder was fifteen sixteen  
Onset of ED aged twelve  
Options offered by CEDS  
Other agencies offered pack to be sent home which was a deterrent  
Other family members have eating disorder  
Other people's comments  
Others advise her to be selfish  
Others assume she has no problems now  
Others can talk to her  
Others did not want come with her to CEDS  
Others focussed on her body  
Others have made her hate self  
Others want to ignore it  
Others were also abused  
Others would not understand  
Own achievement  
own experiences too personal to talk about in groups  
Parent-child ideal  
Parents do not know about ED  
Parents knew she had eating problems  
Parents knowing about ED scared her  
Parents sent her away during summer holidays  
Parents unaware of attendance to CEDS  
Parents would not understand ED  
Parents would worry if they found out about ED  
Partner alcoholic  
Partner did not support her  
Partner dismissed that he was father  
Partner made her feel unwanted  
Partner played games with her  
Partner spiked her drinks  
Partner taunted her  
Partner took advantage of her  
Partner was aware of her difficulties  
Partner was not loving  
People commented on her weight loss  
People could see other people need help if underweight  
People do not understand eating disorder  
People holding her back from recovery  
Point of desperation  
Prefers help from Psychologists  
Prefers individual support  
Prefers to talk to one person about her ED  
Protects self from being hurt and hurting self  
Protects sons  
Punished for not keeping child  
Punished for speaking out  
Punished self  
Put down by father  
Put others first  
Put pressure on self  
Questions self if she was a strong character  
Quiet as a child  
Realised that she did not cause the events  
Realised events were not her fault  
Realised she did not deserve what happened to her



## Appendix 11

Reason for referral was a tummy tuck operation  
Referred by consultant  
Referred via Gp and physiotherapist help  
Regular support  
Rejected by family  
Rejected by father  
Relatives used to joke at other's expense  
Resented that others did not notice or help  
Restrict meals  
Restricted  
Restricted calories  
Restrictive diet  
Ruminating thoughts  
Says she was broken  
Scared of attending  
Second child put into care  
Sees self differently to how others see her  
Self induced vomiting  
Sensitive person  
Sensitive to bullying  
Sexual abuse  
Shame  
She had somebody to love- her son  
Shy and timid as a child  
Sister had passed away  
Sister punished for speaking out  
Some may feel comfortable talking in groups  
Son is grateful to her  
Sons are important to her  
Sons are there for her  
Spent a lot of time with extended family  
Spoke to GP about difficulties with food  
Standing up to family  
Started sports  
Starve self  
Stigma attached to ED  
Still needed support  
Still needs help  
Still wants her mum to say that she loves her  
Stopped eating  
Striving for a particular body image  
Suggests support more accessible  
Supported by mum and brother  
Supporting others  
Supports her children  
Surrounded by familiar faces at GP surgery  
Talks to some about ED  
Tells her sons she is there for them  
Tells self needs to deal with people  
Thinks ED got better as she got older  
thinks she still has an eating disorder  
Thought if you restrict food she would lose weight  
Thought she would be hated if she put on weight  
Thought that she was put through them because she did not speak out  
Thrown out of home  
Tired of trying to give please cousins  
Told GP that she did not want others to know  
Told mother  
Took no risk in people finding out  
Traumatic marriage  
Treated differently to her siblings

## Appendix 11

Treid to tell other helplines and organisations  
Tried to explain impact of taunting to cousins  
Tried to impress parents  
Tried to lose weight  
Tried to please others  
Tried to speak out  
Tried to talk to mother  
Tried to tell GP re: underweight  
Trigger - bad day  
Trigger to ED- one thing go wrong then other thoughts ruminate  
Trigger to ED - people  
Trying to accept who she is  
Tummy tuck operation helped  
Unaware of CEDS existing  
Unaware of consequences of starving before attending CEDS  
Unsupported by both parents  
Unsure if difficulties are part of normality  
Unsure of referral by GP  
unsure of what to expect  
Unsure what an eating disorder clinic meant  
unsure what she would do without ED  
Upset about lying to parents  
Upsetting when parents ask if she has eaten  
Used by partner  
Used food to deal with life  
Used to be unwell due to ED behaviour  
Used to beg mother to let her home  
Used to stay quiet when being taunted  
Used to talk to sister knowing she could not disclose  
Verbally abused  
Violent household  
Violent relationship  
Wanted answers  
Wanted CEDS to answer questions of what had happened to her  
Wanted ED gone  
Wanted help  
Wanted help to understand disordered eating  
Wanted insight  
Wanted issues resolving  
Wanted normality  
Wanted others to understand  
Wanted parents to be proud of her  
Wanted praise  
Wanted solutions to eating disorder  
Wanted to feel wanted  
Wanted to keep child  
Wanted to talk to someone about difficulties  
Wanted to train self to eat properly  
Wants images from past to disappear  
Wants mum to say she is proud of her  
Wants quick solutions  
Wants someone to guide through access  
Wants someone to tell her she will not have difficulties  
Wants to be there for her children  
Wants to be there for the child  
Wants to be well for her daughters  
Wants to get rid of thoughts of the past  
Was admitted as inpatient to Psychiatric unit  
Was afraid parents would think she is not a good daughter  
Was focussed on operation rather than strategies to cope  
Was initially looked after by partner



## Appendix 11

Was insecure  
Was made to feel not good enough  
Was miserable  
Was mocked for ED  
Was not able to show anyone her emotions  
Was not restricting food so others would notice  
Was overweight  
Was overweight so people did not see the signs  
Was put down  
Was targetted by partner  
Was taunted  
Was the youngest girl in family  
Was told she would never be good for a boy she liked  
Was underweight  
Was unsure what calories were  
Was vulnerable  
Weight loss drove her  
Went against family  
Went to college and changed  
Went to GP for help  
Went to GP in the end  
Went to scatter sisters ashes in India  
What others say  
Witnessed abuse  
Witnessed father violence to brother  
Witnessed grandparents violence to brother  
Working on being happy and focusing on self  
Worried about siblings  
Would feel awful about self  
would feel guilty if she told aunt and not parents  
Would not tell parents about EDS as they would worry  
Would think she would "get fat"

Appendix 12 – Table of Higher and Lower Order Categories



Appendix 12 – Table of Higher and Lower Order Categories

South Asian Women		Caucasian Women	
Higher Order Categories	Lower Order Categories	Higher Order Categories	Lower Order Categories
Adverse Childhood Experiences	Sexual abuse Verbal abuse Physical abuse Emotional abuse Neglect Emotional upbringing	Adverse Childhood Experiences	Verbal abuse  Emotional abuse Neglect Emotional upbringing Instability
Effect on Sense of Self	Low self esteem Loneliness Lack of self worth Blaming self Poor body image	Effect on Sense of Self	Low self esteem Loneliness Lack of self worth Blaming self Poor body image
Role of Eating Disorder	Functional Coping mechanism Comfort-self soothing	Role of Eating Disorder	Functional Coping mechanism Comfort-self soothing
Accessing Family Support	No support Uninformed of eating disorder	Accessing Family Support	Supported Aware of eating disorder
Accessing Treatment	Could not cope Needed help	Accessing Treatment	Right time Needed help
Cultural Influences	Rules Restrictions Silence Expectations Stigma		
Negative Consequences of Speaking Out	Fear of being ostracised Fear of letting culture down Fear of stigma to family		